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## ADOPTED

BOARD OF SUPERVISORS  
COUNTY OF LOS ANGELES

14 November 20, 2012

*Sachi A. Hamai*  
SACHI A. HAMAI  
EXECUTIVE OFFICER



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November 20, 2012

### REVISED

The Honorable Board of Supervisors  
County of Los Angeles  
383 Kenneth Hahn Hall of Administration  
500 West Temple Street  
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL TO EXECUTE 19 HIV/AIDS AMBULATORY OUTPATIENT MEDICAL SERVICE CONTRACTS AND 19 HIV/AIDS MEDICAL CARE COORDINATION CONTRACTS, INCLUDING SIX SOLE SOURCE CONTRACTS, FOR SERVICE PLANNING AREAS 2 THROUGH 8 EFFECTIVE ~~NOVEMBER 1, 2012~~ DATE OF BOARD APPROVAL THROUGH FEBRUARY 28, 2015, AMEND AND EXTEND THE TERM OF 18 HIV/AIDS SERVICES CONTRACTS, AND TERMINATE FOR CONVENIENCE FIVE HIV/AIDS SERVICES CONTRACTS (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)**

### SUBJECT

Request approval to award and execute 19 HIV/AIDS Ambulatory Outpatient Medical Services agreements and 19 HIV/AIDS Medical Care Coordination contracts, including six sole source contracts; terminate for convenience two HIV/AIDS Ambulatory Outpatient Services and three Non-Medical Case Management Services Contracts; amend 18 Ambulatory Outpatient Medical and Non-Medical Case Management Contracts to revise the scope of work and make corresponding service/budget adjustments; and delegate authority to rename the service type and extend the term of the 18 contracts.

### **IT IS RECOMMENDED THAT YOUR BOARD:**

1. Authorize and instruct the Director of the Department of Public Health (DPH), or his designee, to execute 19 contracts for the provision of HIV/AIDS Ambulatory Outpatient Medical (AOM) services with the providers identified in Attachment A, effective ~~November 1, 2012~~ date of Board approval through February 28, 2015, for a total maximum obligation of \$27,629,540, 100 percent offset by Ryan White Program (RWP) and net County cost (NCC) funds.

2. Delegate authority to the Director of DPH, or his designee, to execute amendments to the AOM Contracts that extend the term through February 28, 2017; adjust the term through August 31, 2017; allow the rollover of unspent Contract funds; provide an internal reallocation of funds between budgets up to 25 percent of each term's annual base maximum obligation; and/or provide an increase or decrease in funding up to 25 percent above or below each term's annual base maximum obligation 100 percent offset with RWP funds and/or NCC, and an additional exceptional circumstance provision allowing an increase or decrease in funding up to 75 percent above or below each term's annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable Contract term, and make corresponding service adjustments, as necessary, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).
3. Authorize and instruct the Director of DPH, or his designee, to execute 19 new contracts, which include six sole source contracts, for the provision of HIV/AIDS Medical Care Coordination (MCC) services with the providers identified in Attachment B, effective ~~November 1, 2012~~ date of Board approval through February 28, 2015, for a total maximum obligation of \$12,767,076, 100 percent offset by RWP funds.
4. Delegate authority to the Director of DPH, or his designee, to execute amendments to the MCC Contracts that extend the term through February 28, 2017; adjust the term through August 31, 2017; allow the rollover of unspent Contract funds; and/or provide an increase or decrease in funding up to 25 percent above or below each term's annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable contract term, and make corresponding service adjustments, as necessary, subject to review and approval by County Counsel, and notification to your Board and the CEO.
5. Authorize and instruct the Director of DPH, or his designee, to amend 18 HIV/AIDS Services contracts, consisting of 13 AOM and five Non-MCM services contracts, with the providers identified in Attachment C, to terminate the delivery of AOM and Non-MCM service components, including, therapeutic monitoring program, medical case management, and medical specialty, effective ~~November 1, 2012~~ date of Board approval, and to revise the scope of work and make corresponding service/budgets adjustments, that retain the remaining service components, effective ~~November 1, 2012~~ date of Board approval through the current contract term ending February 28, 2013 or March 31, 2013.
6. Delegate authority to the Director of DPH, or his designee, to execute amendments to the 18 HIV/AIDS services contracts with the providers identified in Attachment D,

that rename the service type and extend the term through February 28, 2015 or March 31, 2015 for a total maximum obligation of \$2,926,260, 100 percent offset by RWP funds; adjust the term through August 31, 2015 or September 30, 2015; allow the rollover of unspent contract funds; provide an internal reallocation of funds between budgets up to 25 percent of each term's annual base maximum obligation; and/or provide an increase or decrease in funding up to 25 percent above or below each term's annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable contract term, and make corresponding service adjustments, as necessary, subject to review and approval by County Counsel, and notification to your Board and the CEO.

7. Authorize and instruct the Director of DPH, or his designee, to execute amendments to the 57 contracts identified in Attachments A, B, C, D and E, that revise or incorporate provisions consistent with all applicable State and/or federal laws and regulations, County Ordinances, and Board policy, subject to review and approval by County Counsel.
8. Delegate authority to the Director of DPH, or his designee, to execute change notices to the 57 contracts identified in Attachments A, B, C, D and E, that authorize modifications to or within schedule budget categories, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or corrections of errors in the Contract's terms and conditions.
9. Authorize and instruct the Director of DPH, or his designee, to terminate for convenience two AOM services contracts and three Non-Medical Case Management (Non-MCM) services contracts with the providers identified in Attachment E, upon issuing a 30 calendar day advance written notice, subject to review and approval by County Counsel.

#### **PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION**

Approval of Recommendation 1 will allow DPH to enter into 19 new fee-for-service contracts with community-based providers selected through a Request for Proposal (RFP) process. These contracts will provide vital HIV/AIDS AOM services to the residents of Service Planning areas (SPAs) 2 through 8 of Los Angeles County (County), and will change the payment structure for AOM services from cost reimbursement to fee-for-service. The fee-for-service reimbursement strategy will drive service efficiencies and the delivery of high quality care. To achieve this, payments will be structured around a combination of process and outcome measures. To assist providers in meeting performance targets and resource demands, the reimbursement rate for the first two contract terms (~~November 1, 2012 date of~~ Board approval through February 28, 2013 and March 1, 2013 through February 28, 2014), is set at the mid-range performance rate of \$330.12 per patient per visit. This mid-range

rate is based on a range between \$284.86 and \$375.22. Because performance measures are based on a one-year measurement period, the first assessment of performance and reimbursement rates will occur beginning March 1, 2014. The performance-based rates beginning March 1, 2014 will be based on performance in 2013 and will be set as the rate of reimbursement for 2014. Adjustments in reimbursement rates will be determined based on performance on both the 11 core and 11 supplemental measures for a total of 22 measures, as identified in Attachment G, Fee-For-Service and Additional Reimbursement Incentives Guidelines.

Based upon the review, providers will be paid within the range of \$284.86 to the maximum \$375.22 per patient visit. This base rate will be paid with the expectation that the provider meets established benchmarks with a core set of 11 clinical and performance measures. Rates will be re-negotiated for the remaining 2015 base term based on an annual performance assessment of the 2014 contract period. Those adjustments will be executed using authority delegated by your Board in Recommendation 2 to increase or decrease funding up to 25 percent above or below each term's annual base maximum obligation. If the increases or decreases exceed this delegated authority, DPH will return to your Board for approval.

The services under the fee-for-service contracts will include the provision of medical evaluation and clinical care; access to AIDS Drug Assistance Program enrollment services; access and referral to medical subspecialty care; and access to medical care coordination services, disease monitoring, additional clinically indicated laboratory testing, treatment adherence counseling, and secondary HIV/AIDS prevention in the ambulatory outpatient setting. Previous to this Board letter, DPH used both medical outpatient or "MOP" and AOM interchangeably to describe these services. The RFP was developed using MOP. However, under this Board Letter and for contracting purposes, DPH will use the HRSA approved category name "AOM."

Approval of Recommendation 2 will allow DPH to execute amendments to the 19 AOM Contracts to extend and/or adjust the term of the Contracts; rollover unspent funds; internally reallocate funds between budgets up to 25 percent of the annual base maximum obligation; and/or increase or decrease funding up to 25 percent above or below the annual base maximum obligation 100 percent offset with RWP funds and/or NCC, and/or up to 75 percent under exceptional circumstances, effective upon amendment execution or at the beginning of the applicable contract term, and make corresponding service adjustments, as necessary.

This recommended action will enable DPH to amend contracts to adjust the term for a period of up to six months beyond the expiration date. Such amendments will only be executed if and when there is an unanticipated extension of the term of the applicable grant funding to allow additional time to complete services and utilize grant funding.

The recommendation to allow DPH to increase or decrease funding up to 75 percent above or below the annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable contract term, will only be executed in the event that progress toward health care reform is slowed or the local low-income health plan, Healthy Way LA (HWLA), is not able to enroll qualifying patients with HIV into the plan. This will allow DPH to continue supporting medical outpatient care at the current level using RWP funds, eliminating any potential gap in availability of crucial medical care. This authority is being requested to enhance DPH's efforts to expeditiously maximize grant revenue, consistent with Board Policy 4.070: Full Utilization of Grant Funds.

Recommendation 2 will also enable DPH to amend the AOM Contracts to allow for the provision of additional units of funded services that are above the service level identified in the current Contract, the inclusion of unreimbursed eligible costs, and/or the provision of performance-based reimbursement beginning March 1, 2014, based on the availability of grant funds and grant funder approval. While the County is under no obligation to pay a contractor beyond what is identified in the original executed Contract, the County may determine that the contractor has provided evidence of eligible costs for qualifying contracted services and that it is in the County's best interest to increase the maximum contract obligation as a result of receipt of additional grant funds or a determination that funds should be reallocated. This recommendation has no impact on net County cost.

Approval of Recommendation 3 will allow DPH to enter into 19 contracts, including six sole source contracts, with the same AOM community-based providers to provide HIV/AIDS MCC services. These contracts will support critical HIV/AIDS MCC services to County residents within SPAs 2 through 8. These services include: the provision of clinical and ancillary support services; case conferencing; treatment adherence services; and medical and non-medical case management, linkage, retention, and referral services.

Approval of Recommendation 4 will allow DPH to execute amendments to the 19 MCC Contracts to extend and/or adjust the term of the Contracts; rollover unspent funds; and/or increase or decrease funding up to 25 percent above or below the annual base maximum obligation, effective upon amendment execution or at the beginning of the applicable Contract term, and make corresponding service adjustments, as necessary. This recommended action will enable DPH to amend Contracts to adjust the term for a period of up to six months beyond the expiration date. Such amendments will only be executed if and when there is an unanticipated extension of the term of the applicable grant funding to allow additional time to complete services and utilize grant funding. This authority is being requested to enhance DPH's efforts to expeditiously maximize grant revenue, consistent with Board Policy 4.070: Full Utilization of Grant Funds.

Recommendation 4 will also enable DPH to amend the Contracts to allow for the provision of additional units of funded services that are above the service level identified in the current Contract and/or the inclusion of unreimbursed eligible costs, based on the availability of grant funds and grant funder approval. While the County is under no obligation to pay a contractor beyond what is identified in the original executed Contract, the County may determine that the contractor has provided evidence of eligible costs for qualifying contracted services and that it is in the County's best interest to increase the maximum contract obligation as a result of receipt of additional grant funds or a determination that funds should be reallocated. This recommendation has no impact on net County cost.

Approval of Recommendation 5 will allow DPH to amend 18 HIV/AIDS Services contracts, consisting of 13 AOM and five Non-MCM contracts, terminate the delivery of the AOM and Non-MCM service components that will no longer be provided under these contracts, and revise the scope of work components and related budgets of the remaining services components, reflected in Attachment C. The AOM and Non-MCM components will be replaced with the new AOM and MCC contracts effective date of Board approval.

Approval of Recommendation 6 will allow DPH to execute amendments to the 18 HIV/AIDS Services contracts that will rename the services from AOM and Non-MCM to Mental Health, Psychiatry and/or Benefits Specialty and will extend the term of the contracts for two years beginning March 1, 2013 and April 1, 2013 respectively through the term ending February 28, 2015 and March 31, 2015.

Approval of Recommendation 7 will allow DPH to execute amendments to the 57 Contracts to incorporate provisions consistent with all applicable State and/or federal laws and regulations, County Ordinances, and Board policy.

Approval of Recommendation 8 will allow DPH to execute change notices to the 57 Contracts that authorize modifications to or within schedule budget categories, and corresponding service adjustments, as necessary; changes to hours of operation and/or service locations; and/or corrections of errors in the Contract's terms and conditions.

Approval of Recommendation 9 will allow DPH to terminate for convenience two existing AOM services contracts and three existing Non-MCM services contracts which have been subsumed in the new contracts in order to implement new service components and a new fee-for-service reimbursement system for AOM services.

### **Implementation of Strategic Plan Goals**

The recommended actions support Goal 3, Integrated Services Delivery, of the County's Strategic Plan.

### **FISCAL IMPACT/FINANCING**

The maximum obligation for the 19 new AOM contracts is \$27,629,540, for the period of ~~November 1, 2012~~ date of Board approval through February 28, 2015, 100 percent offset by RWP and NCC funds. The NCC funded portion of these AOM contracts will be determined during the term beginning March 1, 2014, when agency reimbursements rates will be adjusted based on core and supplemental performance measures met. Payments will be based on core measures and supplemental measures met in 2013 and the rates will be paid within the minimum rate of \$284.86 to the maximum rate of \$375.40 per visit, as described in Attachment G, Fee-For-Service and Additional Reimbursement Incentives Guidelines.

The maximum obligation for the 19 new MCC (including the six sole source) contracts is \$12,767,076, for the period of ~~November 1, 2012~~ date of Board approval through February 28, 2015, 100 percent offset by RWP funds.

The maximum obligation to extend the 18 Mental Health Psychiatry and Benefit Specialty contracts is \$2,926,260 for the period March 1, 2013, through February 28, 2015 and April 1, 2013 through March 31, 2015, respectively, 100 percent offset by RWP funds.

Funding for these contracts has been included in DPH's Final Adopted Budget for fiscal year (FY) 2012-13 and will be requested in future FYs, as necessary.

### **FACTS AND PROVISIONS/LEGAL REQUIREMENTS**

The RWP is administered by the U.S. Department of Health and Human Services (DHHS), Health Resource and Services Administration (HRSA), HIV/AIDS Bureau. The RWP is the largest federal program focused exclusively on HIV/AIDS care, and is for individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health coverage, or lack financial resources to get the care they need for their HIV disease. As such, the RWP fills gaps in care not covered by other funding sources.

DPH currently has contracts with agencies to provide the following service categories under AOM services: mental health psychiatric services, early intervention services, benefit specialty services, oral healthcare services, medical case management, therapeutic monitoring program, and medical specialty services (MSS).

Beginning in March 2010, DPH conducted a Request for Proposals (RFP) process for MSS and AOM services. On August 21, 2012, the Board granted DPH approval to enter into contracts with agencies identified through the RFP process to provide MSS services. This Board letter requests approval to enter into contracts for the provision of AOM services with 19 agencies that were identified through the RFP process.

In order to ensure medical care coordination (MCC) services are offered at all AOM sites, DPH proposes to enter into separate contracts with the same 19 agencies identified to provide AOM services to provide MCC services as well. Thirteen of those agencies have been providing MCC services under current contracts, and therefore do not require a sole source contract. The remaining six agencies are not currently funded by DPH to provide MCC services, but as a result of being successful proposers for AOM services will also need to provide MCC services onsite along with AOM services. The agencies will be the legal operators of MCC services at each location.

MCC services were not included in the RFP that DPH released in March 2010 because neither the Los Angeles County Commission on HIV (COH) Standards of Care nor the staffing requirements for MCC services were completed. Since then, the COH has included in the Standards of Care a requirement that all AOM sites must offer MCC services. In order to comply with this mandate, DPH proposes to enter into contracts for MCC services with the 19 agencies identified to provide AOM services. Doing this will also allow DPH to align new requirements as guided by HRSA, DHHS HIV Treatment Guidelines, and the DHHS Prevention and Treatment of Opportunistic Infection Guidelines.

In addition to complying with the COH mandate, providing MCC services at all AOM sites supports the HIV medical home model of care and is key in achieving viral load suppression and maximizing health outcomes. Co-location of these services will allow the agencies to do the following: coordinate clinical and supportive services; promote retention and adherence to complex medical regimens; address patients' barriers to receiving care; and provide access to other onsite wrap-around services.

As required under Board Policy 5.120 and Board Policy 5.100, your Board was notified on October 10, 2012 of DPH's request to increase or decrease funding up to 25 percent above or below the annual base maximum obligation, 75 percent under exceptional circumstances, and DPH's intent to enter into negotiations for Board-approved sole source contracts in excess of \$250,000.

The recommended contracts will be reviewed and approved as to form by County Counsel prior to execution by all parties. Attachments A and B provide funding information for the newly contracted agencies. Attachment C provides information about the contracts to be amended and reflects the AOM and NON-MCM components to be removed. Attachment D provides information about the contracts to be renamed and extended. Attachment E provides information about the contracts to be terminated. Attachment F is the signed Sole Source Checklist. Attachment G provides information about the Fee-For-Service and Additional Reimbursement Incentives Guidelines.

## **CONTRACTING PROCESS**

### *Ambulatory Outpatient Medical*

On June 3, 2009, DPH released an RFP seeking proposals from qualified community-based organizations within SPA 1 to provide HIV/AIDS core medical and support services for SPA 1. Your Board approved the award of these contracts on December 14, 2010.

On March 1, 2010, DPH released an RFP for HIV/AIDS Core Medical Care Services within SPAs 2 through 8. The purpose of the RFP was to purchase effective and high quality comprehensive AOM services and medical subspecialty services (MSS) for people living with HIV/AIDS who meet the County's RWP eligibility requirements. In response to a broad set of technical inquiries raised at the mandatory proposer's conference and through written questions, DPH saw the need to refine the RFP, the RFP was canceled on March 16, 2010.

On March 29, 2010, an RFP Re-Bid was released which included the same four service categories previously solicited, and by the submission due date of June 7, 2010, DPH had received ~~49~~ 22 proposals from 20 agencies, including 19 proposals for HIV/AIDS AOM, one proposal for HIV/AIDS MSS, one proposal for DHS-Delivered HIV/AIDS AOM, and one proposal for DHS-Delivered HIV/AIDS MSS. The delivery of AOM services through DHS will occur at High Desert Health Systems, Olive View Medical Center, Hubert Humphrey Comprehensive Health Center, Martin Luther King Jr. - Multi-Service Ambulatory Care Center (OASIS Clinic), LAC+USC Medical Center, Harbor UCLA Medical Center and Long Beach Comprehensive Health Center. Each of these AOM service delivery sites will also include an MCC component.

An evaluation committee consisting of external and internal review panelists who were experts in the subject matter reviewed the proposals. All evaluators were carefully screened to ensure there were no conflicts of interest, and were required to sign a certification form attesting to this. Proposals were evaluated in accordance with the Evaluation Methodology for Proposals – Policy 5.054 approved by your Board on March 31, 2009. Each proposal's final score was based on the combined scores achieved in the external and internal reviews. Proposals were ranked in score order. All 19 agencies that submitted proposals are recommended for funding. These include 15 current providers and four new providers: St. John's, JWCH Institute, Venice Family Clinic and Central City Health Center. DHS-Delivered AOM and MCC Services will be secured through a Memorandum of Understanding with DHS, therefore, not included for Board approval.

The total amount of funding requested in the proposals far exceeded the funding available. In addition, the total number of clients proposed to be served by the agencies exceeds the number of RWP-eligible clients in the County due to enrollment into Healthy Way LA. Therefore, the recommended funding amounts are based on the number of HIV patients

who are not eligible for services supported by other payer sources each proposing agency actually sees in its clinics.

The recommendation of the award for new AOM services was delayed due to the rebidding of services and emerging HWLA enrollment requirements. In addition, DPH experienced an increase in administrative actions related to the processing of several new grant awards, while facing decreases in staffing.

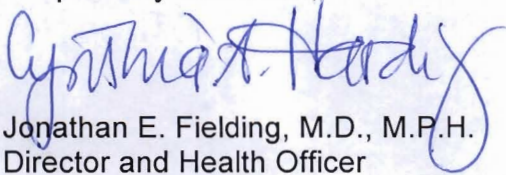
*Medical Care Coordination*

The purpose of MCC services is to reduce or eliminate patients' barriers to achieving viral suppression and maximize health outcomes by providing case management and other wrap-around services on-site. To facilitate this, all agencies recommended for AOM funding are also being recommended for MCC funding. Consistent with the COH Standards of Care, MCC services will be available to eligible patients regardless of the payer of medical care. Proposed funding for each agency is based on the number of patients and their current acuity level, as well as on a standardized staffing pattern and staff budget for MCC developed jointly by DPH and the COH.

**IMPACT ON CURRENT SERVICES (OR PROJECTS)**

Approval of the recommended actions will allow DPH to award new contracts to support the delivery of critical HIV/AIDS AOM and MCC services to County residents within SPAs 2 through 8.

Respectfully submitted,

  
for Jonathan E. Fielding, M.D., M.P.H.  
Director and Health Officer

JEF:MJP:jl  
#02400

Enclosures (7)

c: Chief Executive Officer  
County Counsel  
Executive Officer, Board of Supervisors

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HIV AND STD PROGRAMS  
FUNDING SOURCE: RYAN WHITE PROGRAM (RWP) PART A

## RECOMMENDED NEW AOM CONTRACTS

	Contractor and Agreement Number	Term 1 (Year 22) Date of Board Approval 11/4/12 - 2/28/13	Term 2 (Year 23) 3/1/13 - 2/28/14	Term 3 (Year 24) 3/1/14 - 2/28/15	Total Awarded Maximum Obligation	Service Planning Area(s) Served	Supervisory District(s) Served
1	AIDS Healthcare Foundation PH-Pending	\$ 2,594,215	\$ 5,033,208	\$ 4,507,389	\$ 12,134,812	2 - 8	1 - 4
2	AltaMed Health Services Corporation PH-Pending	\$ 515,056	\$ 969,077	\$ 856,985	\$ 2,341,118	3, 7	1
3	Central City Community Health Center PH-Pending	\$ 44,408	\$ 90,092	\$ 90,092	\$ 224,592	6	1, 2
4	Childrens Hospital Los Angeles PH-Pending	\$ 44,813	\$ 84,241	\$ 74,526	\$ 203,580	4	3
5	City of Long Beach, Department of Health & Human Services PH-Pending	\$ 149,822	\$ 260,957	\$ 222,462	\$ 633,241	8	4
6	City of Pasadena, Public Health Department PH-Pending	\$ 126,115	\$ 215,442	\$ 182,015	\$ 523,572	3	5
7	East Valley Community Health Center PH-Pending	\$ 189,924	\$ 361,139	\$ 321,053	\$ 872,116	3	1, 5
8	El Proyecto del Barrio, Inc. PH-Pending	\$ 120,768	\$ 294,111	\$ 284,677	\$ 699,556	2	3
9	JWCH Institute, Inc. PH-Pending	\$ 44,408	\$ 90,092	\$ 90,092	\$ 224,592	6	2, 4
10	Long Beach Memorial Miller Medical Center, Inc. PH-Pending	\$ 41,777	\$ 76,955	\$ 73,311	\$ 192,043	8	4
11	Northeast Valley Health Corporation PH-Pending	\$ 269,197	\$ 448,366	\$ 374,142	\$ 1,091,705	2	3
12	St. John's Well Child and Family Center PH-Pending	\$ 44,408	\$ 90,092	\$ 90,092	\$ 224,592	6	2
13	St. Mary Medical Center PH-Pending	\$ 272,007	\$ 476,079	\$ 407,005	\$ 1,155,091	8	4
14	Tarzana Treatment Center, Inc. PH-Pending	\$ 52,377	\$ 77,467	\$ 60,671	\$ 190,515	2	3, 5
15	T.H.E. Clinic, Inc. PH-Pending	\$ 130,242	\$ 245,501	\$ 214,803	\$ 590,546	6	2
16	The Los Angeles Gay and Lesbian Community Services Center PH-Pending	\$ 1,232,402	\$ 2,289,416	\$ 1,990,156	\$ 5,511,974	4	3
17	Valley Community Clinic PH-Pending	\$ 72,542	\$ 138,184	\$ 121,635	\$ 332,361	2	3
18	Venice Family Clinic PH-Pending	\$ 44,408	\$ 90,092	\$ 90,092	\$ 224,592	5	2, 3
19	Watts Healthcare Corporation PH-Pending	\$ 58,375	\$ 107,400	\$ 93,167	\$ 258,942	6	2
TOTAL		\$ 6,047,264	\$ 11,437,911	\$ 10,144,365	\$ 27,629,540		

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HIV AND STD PROGRAMS  
FUNDING SOURCE: RYAN WHITE PROGRAM (RWP) PART A**

**RECOMMENDED NEW MCC CONTRACTS**

Contractor and Agreement Number		Term 1 (Year 22) Date of Board Approval 4/14/42 - 2/28/13	Term 2 (Year 23) 3/1/13 - 2/28/14	Term 3 (Year 24) 3/1/14 - 2/28/15	Total Awarded Maximum Obligation	Service Planning Area(s) Served	Supervisory District(s) Served
<b>SOLE SOURCE CONTRACTS</b>							
1	Central City Community Health Center PH-Pending	\$ 19,500 \$	\$ 58,500 \$	\$ 58,500 \$	\$ 136,500	6	1, 2
2	Childrens Hospital Los Angeles PH-Pending	\$ 39,000 \$	\$ 117,000 \$	\$ 117,000 \$	\$ 273,000	4	3
3	El Proyecto del Barrio, Inc PH-Pending	\$ 39,000 \$	\$ 117,000 \$	\$ 117,000 \$	\$ 273,000	2	3
4	St. John's Well Child and Family Center PH-Pending	\$ 19,500 \$	\$ 58,500 \$	\$ 58,500 \$	\$ 136,500	6	2
5	The Los Angeles Gay & Lesbian Community Services Center PH-Pending	\$ 494,720 \$	\$ 1,484,161 \$	\$ 1,484,161 \$	\$ 3,463,042	4	3
6	Venice Family Clinic PH-Pending	\$ 39,000 \$	\$ 117,000 \$	\$ 117,000 \$	\$ 273,000	5	2, 3

**NON-SOLE SOURCE CONTRACTS**

7	AIDS Healthcare Foundation PH-Pending	\$ 286,257 \$	\$ 858,771 \$	\$ 858,771 \$	\$ 2,003,799	2 - 8	1 - 4
8	AltaMed Health Services Corporation PH-Pending	\$ 68,677 \$	\$ 206,032 \$	\$ 206,032 \$	\$ 480,741	3, 7	1
9	City of Long Beach, Department of Health & Human Services PH-Pending	\$ 153,919 \$	\$ 461,757 \$	\$ 461,757 \$	\$ 1,077,433	8	4
10	City of Pasadena, Public Health Department PH-Pending	\$ 175,497 \$	\$ 526,490 \$	\$ 526,490 \$	\$ 1,228,477	3	5
11	East Valley Community Health Center PH-Pending	\$ 77,794 \$	\$ 233,382 \$	\$ 233,382 \$	\$ 544,558	3	1, 5
12	JWCH Institute, Inc. PH-Pending	\$ 19,500 \$	\$ 58,500 \$	\$ 58,500 \$	\$ 136,500	6	2, 4
13	Long Beach Memorial Miller Medical Center, Inc. PH-Pending	\$ 52,876 \$	\$ 158,627 \$	\$ 158,627 \$	\$ 370,130	8	4
14	Northeast Valley Health Corporation PH-Pending	\$ 69,285 \$	\$ 207,856 \$	\$ 207,856 \$	\$ 484,997	2	3
15	St. Mary Medical Center PH-Pending	\$ 98,458 \$	\$ 295,374 \$	\$ 295,374 \$	\$ 689,206	8	4
16	Tarzana Treatment Center, Inc. - SPA 2 PH-Pending	\$ 39,000 \$	\$ 117,000 \$	\$ 117,000 \$	\$ 273,000	2	3, 5
17	T.H.E. Clinic, Inc. PH-Pending	\$ 44,367 \$	\$ 133,100 \$	\$ 133,100 \$	\$ 310,567	6	2
18	Valley Community Clinic PH-Pending	\$ 43,151 \$	\$ 129,454 \$	\$ 129,454 \$	\$ 302,059	2	3
19	Watts Healthcare Corporation PH-Pending	\$ 44,367 \$	\$ 133,100 \$	\$ 133,100 \$	\$ 310,567	6	2
<b>TOTAL</b>		<b>\$ 1,173,148 \$</b>	<b>\$ 3,519,443 \$</b>	<b>\$ 3,519,443 \$</b>	<b>\$ 8,212,034</b>		

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HIV AND STD PROGRAMS

CONTRACTS RECOMMENDED FOR RESTRUCTURING THAT INCLUDES TERMINATION OF THE AOM AND NON-MCM COMPONENTS OF THE CONTRACT

	Contractor	Contract No.	Services Terminating Effective November 1, 2012 <u>Date of Board Approval</u>	Remaining Services Effective <u>Date of Board Approval</u> November 1, 2012 through February 28, 2013
1	AIDS Healthcare Foundation	H-209006	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Case Management, Medical Specialty	Mental Health, Psychiatry, Early Intervention Program and Benefits Specialty
2	AltaMed Health Services	H-209203	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Specialty	Mental Health, Psychiatry
3	Childrens Hospital Los Angeles	H-209022	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program	Mental Health, Psychiatry
4	City of Pasadena	H-209212	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Case Management, Medical Specialty	Mental Health, Psychiatry
5	East Valley Community Health Center	H-209088	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program	Mental Health, Psychiatry
6	El Proyecto Del Barrio	H-209031	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Specialty	Mental Health, Psychiatry and Oral Health Care
7	Long Beach Memorial Medical Center	H-209237	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Specialty	Mental Health, Psychiatry
8	Northeast Valley Health Corporation	H-209014	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Case Management, Medical Specialty	Mental Health, Psychiatry and Early Intervention Program
9	St. Mary Medical Center	H-209015	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Case Management,	Benefits Specialty and Early Intervention Program and Oral Health Care
10	T.H.E. Clinic, Inc.	H-209012	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Case Management	Mental Health, Psychiatry
11	Tarzana Treatment Center	H-209018	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Case Management, Medical Specialty	Mental Health, Psychiatry
12	The Los Angeles Gay & Lesbian Community Services Center	H-209013	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Specialty	Mental Health, Psychiatry
13	Watts Healthcare Foundation	H-209575	Ambulatory/Outpatient Medical Services, Therapeutic Monitoring Program, Medical Specialty	Mental Health, Psychiatry
	Contractor	Contract No.	Services Terminating Effective November 1, 2012 <u>Date of Board Approval</u>	Remaining Services Effective <u>Date of Board Approval</u> November 1, 2012 through March 31, 2013
14	AltaMed Health Services Corp.	H-206921	Non-Medical Case Management Services	Benefit Specialty
15	City of Long Beach	H-210813	Non-Medical Case Management Services	Benefit Specialty
16	East Valley Community Health Center	H-210825	Non-Medical Case Management Services	Benefit Specialty
17	Northeast Valley Health Corporation	H-208023	Non-Medical Case Management Services	Benefit Specialty
18	Tarzana Treatment Center	H-210795	Non-Medical Case Management Services	Benefit Specialty

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HIV AND STD PROGRAMS  
FUNDING SOURCE: RYAN WHITE PROGRAM (RWP) PART A

## RECOMMENDED CONTRACT EXTENSIONS

Contractor	Contract No.	Previous Service Type	Restructured Service Type	Term 1 (Year 23) 3/1/13 - 2/28/14	Term 2 (Year 24) 3/1/14 - 2/28/15	Total Awarded Maximum Obligation	Service Planning Area(s) Served	Supervisory District(s) Served
TERM 1: 3/1/13 - 2/28/14; TERM 2: 3/1/14 - 2/28/15								
1 AIDS Healthcare Foundation	H-209006	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 353,085	\$ 309,705	\$ 662,790	2 - 8	1 - 4
2 AltaMed Health Services	H-209203	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 70,000	\$ 70,000	\$ 140,000	3 - 7	1 - 4
3 Childrens Hospital Los Angeles	H-209022	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 60,000	\$ 60,000	\$ 120,000	4	3
4 City of Pasadena	H-209212	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 75,000	\$ 75,000	\$ 150,000	3	5
5 East Valley Community Health Center	H-209088	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 50,000	\$ 50,000	\$ 100,000	3	1, 5
6 Long Beach Memorial Medical Center	H-209237	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 55,000	\$ 55,000	\$ 110,000	8	4
7 Northeast Valley Health Corporation	H-209014	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 56,235	\$ 56,235	\$ 112,470	2	3
8 St. Mary Medical Center	H-209015	Ambulatory Outpatient Medical	Benefits Specialty	\$ 65,360	\$ 59,660	\$ 125,020	8	4
9 T.H.E. Clinic, Inc.	H-209012	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 60,000	\$ 60,000	\$ 120,000	6	2
10 Tarzana Treatment Center	H-209018	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 40,000	\$ 40,000	\$ 80,000	2	3
11 The Los Angeles Gay & Lesbian Community Services Center	H-209013	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 129,620	\$ 129,620	\$ 259,240	4	3
12 Watts Healthcare Foundation	H-209575	Ambulatory Outpatient Medical	Mental Health, Psychiatry	\$ 70,000	\$ 70,000	\$ 140,000	6	2
TERM 1: 4/1/13 - 3/31/14; TERM 2: 4/1/14 - 3/31/15								
Contractor	Contract No.	Previous Service Type	Restructured Service Type	Term 1 (Year 23) 4/1/13 - 3/31/14	Term 2 (Year 24) 4/1/14 - 3/31/15	Total Awarded Maximum Obligation	Service Planning Area(s) Served	Supervisory District(s) Served
13 AltaMed Health Services Corp.	H-206921	Non-Medical Case Management	Benefits Specialty	\$ 92,080	\$ 82,840	\$ 174,920	7	1
14 City of Long Beach	H-210813	Non-Medical Case Management	Benefits Specialty	\$ 78,460	\$ 75,280	\$ 153,740	8	4
15 City of Pasadena	PH-002188	Non-Medical Case Management	Benefits Specialty	\$ 57,080	\$ 54,320	\$ 111,400	3	5
16 East Valley Community Health Center	H-210825	Non-Medical Case Management	Benefits Specialty	\$ 40,920	\$ 37,620	\$ 78,540	3	1, 5
17 Northeast Valley Health Corporation	H-208023	Non-Medical Case Management	Benefits Specialty	\$ 45,000	\$ 38,880	\$ 83,880	2	3
18 Tarzana Treatment Center	H-210795	Non-Medical Case Management	Benefits Specialty	\$ 102,820	\$ 101,440	\$ 204,260	2	3
GRAND TOTAL				\$ 1,500,660	\$ 1,425,600	\$ 2,926,260		

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HIV AND STD PROGRAMS

## RECOMMENDED CONTRACT TERMINATIONS

	Contractor	Contract No.	Service	Current Contract Term	*Effective Date of Termination
1	City of Long Beach	H-209210	Ambulatory/Outpatient Medical Services	3/1/12 - 2/28/13	11/30/12 12/21/2012
2	Valley Community Clinic	H-209017	Ambulatory/Outpatient Medical Services	3/1/12 - 2/28/13	11/30/12 12/21/2012
3	JWCH Institute, Inc.	H-210816	Non-Medical Case Management Services	4/1/12 - 3/31/13	11/30/12 12/21/2012
4	Long Beach Memorial Medical Center	H-209233	Non-Medical Case Management Services	4/1/12 - 3/31/13	11/30/12 12/21/2012
5	Watts Healthcare Corporation	H-210822	Non-Medical Case Management Services	4/1/12 - 3/31/13	11/30/12 12/21/2012

\*Effective Date is predicated by a October 30, 2012 Board Approval and a corresponding 30 day notice. This matter is subject to Board Approval.

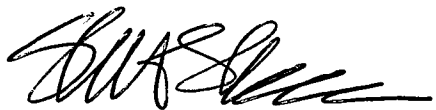
**SOLE SOURCE CHECKLIST****MEDICAL CARE COORDINATION:**

Central City Community Health Center; Children's Hospital Los Angeles; El Proyecto del Barrio; St. John's Well Child and Family Center; Los Angeles Gay & Lesbian Community Services Center; and Venice Family Clinic

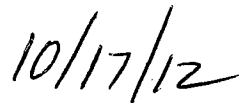
Check (✓)	<b>JUSTIFICATION FOR SOLE SOURCE PROCUREMENT OF SERVICES</b>  <i>Identify applicable justification and provide documentation for each checked item.</i>
	➤ Only one bona fide source for the service exists; performance and price competition are not available.
	➤ Quick action is required (emergency situation)
	➤ Proposals have been solicited but no satisfactory proposals were received.
	➤ Additional services are needed to complete an ongoing task and it would be prohibitively costly in time and money to seek a new service provider.
	➤ Maintenance service agreements exist on equipment which must be serviced by the authorized manufacturer's service representatives.
	➤ It is most cost-effective to obtain services by exercising an option under an existing contract.
	➤ It is the best interest of the County (e.g., administrative cost savings, too long a learning curve for a new service provider, etc.).
✓	➤ Other reason. Please explain:  The six providers are being recommended as sole source to ensure that HIV/AIDS Medical Care Coordination (MCC) services are available at each HIV/AIDS Ambulatory Outpatient Medical (AOM) site in order to comply with the Commission on HIV's Standards of Care and the Department of Health and Human Services' (DHHS) HIV Treatment Guidelines and Prevention and Treatment of Opportunistic Infection Guidelines.  The Department of Public Health (DPH) is recommending all 19 AOM providers be awarded MCC contracts to support full implementation of an HIV medical home model of care. Of the 19 providers awarded MCC contracts,

13 providers are currently funded by DPH to provide Medical Case Management (MCM) and Non-Medical Case management (Non-MCM) services, which are service modalities that include medical/clinical appointment follow-up and/or review of medication/treatment adherence and counseling, education, and outreach services (non-medical/clinical), respectively. Upon consultation with County Counsel, it was determined that only six of the 19 proposed MCC contracts were sole source contracts, as the remaining 13 providers are existing MCM and/or Non-MCM providers whose contracts will be converted to MCC contracts. It was determined that the existing MCM and Non-MCM providers were not sole source contracts as the proposed MCC services are the combination/unification of MCM and Non-MCM services under one umbrella service modality. MCC services include the provision of clinical and ancillary support services; case conferencing; treatment adherence services; and medical and non-medical case management, linkage, retention, and referral services. MCC will now replace the MCM and Non-MCM contracts and include enhanced activities which support the coordination of clinical and ancillary services for the clients. After the term ending March 31, 2013, there will no longer be any Non-MCM or MCM contracts because all case management activities will occur under the 19 MCC contracts. There will be no gap in service or loss of services to clients, as MCC will enhance services to clients because they now will receive case management services under one roof. The integration of MCM and Non-MCM, under MCC will eliminate the current problems with stand-alone MCM and Non-MCM service contracts that resulted in service duplication, lack of proper coordination between medical providers and others in the HIV continuum of care.

The remaining six providers - those which are being proposed for sole source contracts under this Board action, including the LA Gay & Lesbian Center, Venice Family Clinic, and El Proyecto del Barrio have HIV service delivery experience including case management services. These agencies, as well as Central City Community Health Center, Children's Hospital Los Angeles, and St. John's Well Child and Family Center already provide non-HIV case management services through other funding streams.



Sheila Shima  
Deputy Chief Executive Officer, CEO



Date

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Payment for services provided shall be subject to the Fee-For-Service Reimbursement and Additional Reimbursement Incentives provisions described below.

### HIV/AIDS Medical Outpatient Services Fee-For-Service (FFS) Reimbursement

The fee-for-service reimbursement guidelines support quality of care and efficiency of services performed. To achieve this, payments are structured around a combination of process and outcome measures. For Years 1 and 2, providers will be reimbursed at a rate of \$330.12 per patient visit. In Year 3, providers will receive a base payment rate of \$284.86 but may be eligible for a payment rate as high as \$375.22 based on their performance during the prior year. This base rate will be paid with the expectation that the provider meets established benchmarks with a core set of eleven (11) clinical and performance measures, listed in Table 1.

**Table 1.** Core Measures

Measure	Benchmark
1.1 ART for pregnant women	100%
1.2 ART for CD4 <500	95%
1.3 PCP prophylaxis	95%
1.4 Adherence assessment and counseling	95%
1.5 Cervical cancer screen	90%
1.6 Hepatitis C screen	90%
1.7 HIV risk counseling	95%
1.8 Syphilis screen	90%
1.9 Tuberculosis screen	75%
1.10 Patient satisfaction survey response	100%
1.11 Data validation (Casewatch)	75%

Providers will qualify for additional reimbursement incentives only if performance on each of the 11 core measures meets or exceeds the established benchmark during the measurement year. Providers, who meet the established benchmarks on all 11 core measures, will be eligible to obtain additional reimbursement for a total of nine (9) Part A supplemental measures, listed in Table 2A and two (2) Part B supplemental measures listed in Table 2B.

**Table 2A.** Part A Supplemental Measures

Measure	Service Score	Reimbursement per Measure (\$3.03 x service score)	Benchmark
2.1 Chlamydia screen	1	\$3.03	90%
2.2 Gonorrhea screen	1	\$3.03	90%
2.3 Pneumococcal vaccination	1	\$3.03	85%
2.4 Influenza vaccination	1	\$3.03	75%
2.5 Hepatitis B screen	2	\$6.06	90%
2.6 Substance abuse assessment	3	\$9.09	90%
2.7 Mental health assessment	3	\$9.09	90%
2.8 Hepatitis B vaccination	3	\$9.09	90%
2.9 Tobacco cessation counseling	3	\$9.09	90%

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

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Part A supplemental measures include a total of nine (9) measures. Each of the nine Part A supplemental measures has been assigned a service score that reflects the level of complexity and time required to complete the measure. Service scores for each of the supplemental measures are given a rating from 1 to 3. A rating of 1 indicates a measure requiring minimal effort and resources to complete or a low complexity measure. A rating of 2 indicates a measure requiring moderate effort and resources to complete or a moderate complexity measure. A rating of 3 indicates a measure requiring significant effort and resources to complete or a significant complexity measure.

The provider's rate of Part A supplemental reimbursement per patient is based on the number of Part A supplemental measures that meets or exceeds the established benchmark for the clinic population. To calculate this rate, the service score for each Part A performance measure is multiplied by \$3.03, and then added to the base rate of \$284.86. Providers will be paid at an increased rate per patient visit for each additional Part A supplemental measure for which performance meets or exceeds the established benchmark.

**Table 2B.** Part B Supplemental Measures

Measure		Reimbursement	Benchmark
2.10	Medical visits	\$18.00	90%
2.11	Viral load suppression <200 copies/mL when on ART	\$18.00	80%

Part B supplemental measures include a total of two (2) outcome measures reimbursed at \$18.00 each when the established benchmarks are met. Providers will qualify for additional Part B supplemental reimbursement only if performance on each of the 11 core measures meets or exceeds the established benchmark during the measurement year.

The provider's total amount of Part A and B supplemental reimbursement per patient visit is based on the number of Part A and B supplemental measures that meet or exceed the established benchmark for the overall clinic population. This amount is added to the base rate of \$284.86 and the rate paid for any Part A and B supplemental measure for which performance meets or exceeds the established benchmark. If all eleven supplemental performance measure benchmarks are met, reimbursement will be at the maximum rate of \$375.40 per patient visit.

Because performance measures are based on a one-year measurement period, the first assessment of performance and reimbursement rates will occur after Year 2. To assist providers in meeting performance targets and resource demands, the reimbursement rate for Year 1 and 2 only is set at the higher rate of \$330.12 per patient per visit. This rate is mid way between the base reimbursement rate of \$284.86 and the maximum rate of \$375.22. After the calendar year 2013 performance review has been completed, performance-based rates will be set as the rate of reimbursement for Year 3. Rates will be re-negotiated based on an annual performance assessment for the contract period.

### Sampling for Performance Measures

Patients with 2 or more visits in the measurement year will be eligible for inclusion in the sampling for performance evaluation. The 2-visit minimum is used to ensure that providers have the opportunity to perform the necessary screens, vaccination and counseling that would

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

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otherwise be difficult or impossible with just a single patient visit. The overall clinic population will be used in the sample and not only Ryan White eligible patients.

A standardized sampling methodology developed by the National HIVQUAL Project will be used to determine the number of patient records to be sampled at the DHSP on site reviews. It is expected that all providers enter patient level data on performance measures into DHSP's data system as described below.

### **Patients Who Switch Providers during the Measurement Year**

When a patient switches to a different clinic within the DHSP network of clinics during the measurement year for reasons that include but may not be limited to moving to another part of the County or wanting a more convenient provider, the patient may possibly only have one medical visit at the previous clinic. DHSP will use medical visit data from the receiving clinic, if available, for the remainder of the measurement year such that both the previous clinic and the receiving/current clinic receive credit for medical visits occurring two or more times at least 3 months apart during the measurement year.

### **Patient Satisfaction Survey (Core)**

Patient satisfaction surveys are an essential tool to shaping patient centered care. Surveys allow for the quick identification of problems that patients experience and create a space for dialogue with patients, letting them know that their feedback is critical to providing effective and efficient care. The purpose of this measure is to determine whether the agency has implemented a process to routinely administer patient satisfaction surveys to its clinic population. This measure also determines the response rate of patients who received a patient satisfaction survey during the measurement year, which is important in considering the generalizability of the findings.

The table below can be used to identify the number of completed surveys needed for various clinic sizes. The clinic size is determined by the number of providers (MD, DO, PA, or NP) who are seeing patients in the clinic regardless of the provider's FTE or the number of patients they see. The designated number of completed patient surveys determined by the table below, must be obtained for *every provider* who practices in the clinic.

	Number of Providers in the Clinic		
	<5	5-9	=/> 10
Number of Completed Surveys Per Provider Per Year	15	10	5

For example: a clinic with 8 providers would need to obtain a minimum of 10 completed patient surveys for each of the 8 providers per measurement year. If the clinic has fewer than 5 providers, a minimum of 15 returned/completed surveys per provider are needed for every provider in the clinic.

The eligible population for survey includes all clinic patients with at least 1 medical visit during the measurement year and is not limited to Ryan White Program patients. Providers with a smaller patient population should administer enough surveys during the measurement year to

**FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**

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obtain no less than the required number of completed surveys per provider indicated in the above table.

**Data Validation (Core)**

The purpose of this measure is to determine the percentage of medical records reviewed during the measurement period that demonstrate consistency between DHSP's data system and the client's medical record (chart or electronic) with regard to the following thirteen (13) data elements.

1. Age
2. Ethnicity
3. Gender
4. Antiretroviral therapy (ART) in pregnancy
5. CD4 T-cell count testing date and result
6. Viral load testing date and result
7. ART use
8. PCP prophylaxis for CD4<200
9. ART adherence assessment and counseling date
10. Cervical pap smear screening date and result
11. Hepatitis C screening date and result
12. Syphilis screening date and result
13. Tuberculosis screening date and result

Providers will ensure that the above data elements are entered into DHSP's data system either manually or through an electronic data interface. Data validation will be performed through a medical records review of these elements and comparing that documentation to data in DHSP's data system. The eligible population for survey includes Ryan White Program patients with at least 2 medical visits during the measurement year. The threshold for compliance is set at 75% which means that at least 75% of medical records reviewed will have all 13 data elements reflected in each patient's medical record and in DHSP's data system.

**Utilization of Medical Visits and Reimbursement of Additional Visits**

Providers will furnish medical visits to the minimum number of clients to be served as stipulated in this contract. To ensure the appropriate utilization of medical visits, a maximum of 10 visits per patient per year is established. The 10-visit per patient per year threshold only applies to Ryan White Program patients.

Each clinic will routinely track the number of medical visits per patient per year, as well as the clinic's overall total number of visits for the entire clinic patient population based on the total number of patients to be served.

Tracking medical visit utilization is essential in providing patients with access to needed clinical and medical care and follow-up while ensuring that providers adhere to their established budgeted allocations. Given that there are conditions and special circumstances where some patients may need more medical visits than the established 10-visit per year threshold, providers will follow the DHSP review and approval process outlined in the protocol below in order to ensure reimbursement for those additional visits.

The DHSP review process will be retrospective to ensure that patient care is not compromised. The provider will not be able to bill any more visits over the 10-visit threshold without DHSP's

**FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**

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approval. Within this process, providers will have the option to request up to three (3) additional visits for patients that have reached the 10-visit threshold, by providing appropriate justification as per the protocol outlined below.

There are two scenarios for patients exceeding their 10-visit per year threshold. Each scenario requires action as follows:

Scenario 1 - A patient exceeds the 10-visit per year threshold but overall total number of visits for the clinic's Ryan White Program patients remains under the maximum allowed total visits per the approved budget.

Provider will request for a retrospective (or prospective, if preferred) review of the visit(s) in question and approval for those visits and future additional visits up to three visits. DHSP will review each patient's case and render its decision to approve visits incurred over the 10-visit threshold and may authorize up to 3 additional future visits or disapprove the visit(s) in question. Visits over the 10-visit threshold that are not approved by DHSP pursuant to its review, will not be reimbursed.

Scenario 2

A patient exceeds the 10-visit per year threshold and the clinic exceeds overall total number of Ryan White Program patient visits allowed per the approved budget.

In this scenario, provider will request for a retrospective review of the additional visit(s) in question and approval for those visits and future additional visits up to three visits. In this scenario, the provider will not be able to bill any additional visits in Casewatch for these patients, without DHSP's approval. DHSP will review each patient's case and render its decision to approve the visits in question and may authorize up to 3 additional future visits or disapprove the additional visit(s) in question. Additional visits over the 10-visit threshold that are not approved by DHSP will not be reimbursed.

**Protocol for DHSP Case Review, Decision and Appeals Process for Medical Visits Exceeding the 10-Visit Per Year Threshold**

When a patient exceeds the 10-visit threshold per patient per year, the following steps will be followed:

1. Providers will routinely track the number of medical visits per patient per year, as well as the clinic's overall total number of visits for the entire clinic patient population based on the total number of patients to be served.
2. Provider complete a request for review and approval to DHSP and include justification for the visit(s) in question and any additional future visit up to three (3) visits. Provider will send the request to DHSP via:

a. Mail: DHSP  
Attention: OMD/UM Section  
600 S. Commonwealth Avenue, 10<sup>th</sup> Floor  
Los Angeles, CA 9005

**FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**

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- b. Secure Fax: (213) 252-4506
- 3. DHSP will review the request/justification to determine if the documentation provided supports the level of service requested requiring the additional medical visit(s). DHSP's decision will be based on a review of information provided on the request form and when necessary, consultation with the provider and/or a site visit to review the patient's medical records.
- 4. DHSP will render a decision to approve or disapprove the request.
  - a. Approved Requests. DHSP has determined that documentation received contains the required justifications for the level of service requested. DHSP will approve the visit(s) in question. Up to 3 additional future visits will also be approved per request and will be reimbursed under the specific provisions outlined in case scenarios 1 and 2 above.
  - b. Disapproved Requests. DHSP has determined that documentation received does not meet criteria for approval of the additional visit(s) requested. In this case, DHSP will issue an "adverse determination" letter to the provider which will include the specific reasons for disapproving the request.
- 5. The provider accepts DHSP's decision or files an appeal in response to DHSP's "adverse determination" decision by submitting a request to appeal. Provider sends the appeal to DHSP by mail or secure fax as indicated above.
- 6. DHSP will review the appeal. If the appeal is denied, DHSP will send a final "adverse determination" letter to the provider that will include the specific reasons for the denial.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

<b>Performance Measure 1.1:</b> Antiretroviral therapy (ART) for pregnant women	
<b>Description:</b> Percentage of pregnant women with Human Immunodeficiency Virus (HIV) infection who are prescribed ART in the measurement year.	
<b>Numerator:</b>	Number of HIV-infected pregnant women who were prescribed ART during the second and third trimester in the measurement year.
<b>Denominator:</b>	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, <sup>1</sup> at least twice in the measurement year.
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patients<sup>2</sup> whose pregnancy is terminated by spontaneous or induced abortion.</li> <li>2. Pregnant patients who are in the first trimester and newly enrolled in care during last three months of the measurement year.</li> <li>3. Patients with documented referral to another perinatal HIV care program.</li> <li>4. Patients with documented refusal of ART offered by provider.</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> <li>a. If yes, is the patient female? (Y/N) <ol style="list-style-type: none"> <li>i. If yes, was she pregnant during the reporting period? (Y/N) <ol style="list-style-type: none"> <li>1. If yes, was she on ART during this reporting period? (Y/N)</li> </ol> </li> </ol> </li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Ryan White Program Data Report, Section 5, Item 53 may provide data useful in establishing a baseline for this performance measure</li> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<p>No national benchmarks available at this time.</p> <p>DHSP Benchmark = 100%</p>
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"> <li>○ Rate of perinatal transmission in the measurement year</li> <li>○ Number of events of perinatal transmission in the measurement year</li> </ul>
<b>Basis for Selection:</b>	
<p>Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. ART can reduce perinatal HIV-1 transmission by nearly 70%.<sup>3</sup></p> <p>Measure reflects important aspect of care that significantly impacts survival, mortality, and hinders transmission. Data collection is currently feasible and measure has a strong evidence</p>	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

base supporting the use.

**U.S. Public Health Service Guidelines:**

Health care providers considering the use of antiretroviral agents for HIV-1 infected women during pregnancy must take into account two separate but related issues:

- Antiretroviral treatment of maternal HIV-1 infection, and
- Antiretroviral chemoprophylaxis to reduce the risk for perinatal HIV-1 transmission

The benefits of ART for a pregnant woman must be weighed against the risk of adverse events to the woman, fetus, and newborn. Although ZDV chemoprophylaxis alone has substantially reduced the risk for perinatal transmission, antiretroviral monotherapy is now considered suboptimal for treatment of HIV-1 infection, and combination drug regimens are considered the standard of care for therapy. Initial evaluation of an infected pregnant woman should include an assessment of HIV-1 disease status and recommendations regarding antiretroviral treatment or alteration of her current antiretroviral regimen.<sup>3</sup>

**References/Notes:**

<sup>1</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>2</sup> “Patients” include all patients aged 13 years or older.

<sup>3</sup> Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. September 14, 2011. [www.aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf](http://www.aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf).

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.2: ART for CD4 <500																									
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection and CD4 T-cell counts <500 cells/mm <sup>3</sup> who are prescribed ART in the measurement year.																									
<b>Numerator:</b>	Number of HIV-infected patients with CD4 T-cell counts <500 cells/mm <sup>3</sup> or and AIDS-defining condition who were prescribed an ART regimen <sup>2</sup> within the measurement year.																								
<b>Denominator:</b>	Number of HIV-infected patients who have: <ul style="list-style-type: none"><li>• A CD4 T-cell count &lt; 500 cells/mm<sup>3</sup> or an AIDS-defining condition,<sup>2</sup> and</li><li>• At least two medical visits with a provider with prescribing privileges,<sup>3</sup> in the measurement year</li></ul>																								
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"><li>1. Patients newly enrolled in care during last three months of the measurement year.</li><li>2. Patients with documented refusal to take ART in medical record.</li></ol>																								
<b>Data Element:</b>	<ol style="list-style-type: none"><li>1. Is the patient HIV-infected (Y/N)<ol style="list-style-type: none"><li>a. If yes, is the patient diagnosed with CDC-defined AIDS? (Y/N)<ol style="list-style-type: none"><li>i. If yes, was the patient prescribed ART during the reporting period? (Y/N)<ol style="list-style-type: none"><li>1. If yes, does the patient have two or more CD4 counts &lt;500 cells/mm<sup>3</sup>? (Y/N)<ol style="list-style-type: none"><li>A. If yes, was the patient prescribed ART during the reporting period? (Y/N)</li></ol></li></ol></li></ol></li></ol></li></ol>																								
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>• Ryan White Program Data Report, Section 2, Items 26 and 31 may provide data useful in establishing a baseline for this performance measure</li><li>• Electronic Medical Record/Electronic Health Record</li><li>• CAREWare, Lab Tracker, or other electronic data base</li><li>• HIVQUAL reports on this measure for grantee under review</li><li>• Medical record data abstraction by grantee of a sample of records</li></ul>																								
<b>National Goals, Targets, or Benchmarks for Comparison</b>	DHSP Benchmark: 95% CDC and HIVRN data consistent that 80% of those in care “eligible for ART’s” <sup>4,5,6</sup> National HIVQUAL-US Data: <sup>6,7</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td></tr><tr><td>Top 10%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Top 25%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Median*</td><td>100%</td><td>88.9%</td><td>95.7%</td><td>100%</td></tr></table> *from HAB data base						2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	Median*	100%	88.9%	95.7%	100%
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Median*	100%	88.9%	95.7%	100%																					
<b>Outcome Measures for</b>	<ul style="list-style-type: none"><li>○ Rate of opportunistic infections in the measurement year</li><li>○ Rate of HIV-related hospitalizations in the measurement year</li></ul>																								

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

<b>Consideration:</b>	○ Mortality rates
<b>Basis for Selection:</b>	
Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating patients with AIDS-defining conditions and patients with CD4 T-cells between 350 and 500 cells/mm <sup>3</sup> . <sup>2</sup> Measure reflects important aspect of care that significantly impacts survival, mortality, and transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.	
<b>U.S. Public Health Service Guidelines:</b>	
“Antiretroviral therapy should be initiated in patients with a history of an AIDS-defining illness or with a CD4 T-cell count between 350 and 500 cells/mm <sup>3</sup> .” <sup>2</sup>	
<b>References/Notes:</b>	
<sup>1</sup> “Patients” include all patients aged 13 years or older. <sup>2</sup> “Randomized controlled trials provide evidence supporting the benefit of ART in patients with CD4 counts <350 cells/mm <sup>3</sup> . However, such evidence showing benefit for patients with higher CD4 cell counts is not yet available. Based on cumulative observational cohort data demonstrating benefits of ART in reducing AIDS- and non-AIDS associated morbidity and mortality, the Panel now recommends ART for patients with CD4 count between 350 and 500 cells/mm <sup>3</sup> . For patients with CD4 count >500 cells/mm <sup>3</sup> , panel members are evenly divided: 50% favor starting ART at earlier stages of HIV disease; 50% view initiating therapy at this stage as optional. Panel members favoring earlier initiation of therapy base their recommendation on several recent developments: (1) report from at least one recent cohort study demonstrating survival benefit with initiation of ART at CD4 count >500 cells/mm <sup>3</sup> ; (2) growing awareness that untreated HIV infection may be associated with development of many non-AIDS-defining diseases, including cardiovascular disease, kidney disease, liver disease, and malignancy; (3) availability of ARV regimens that are more effective, more convenient, and better tolerated than ARV combinations no longer in use; and (4) increasing evidence that effective ART reduces HIV transmission. The other 50% of the Panel members feel that current evidence does not definitively demonstrate clear benefit of ART in all patients with CD4 count >500 cells/mm <sup>3</sup> . They also feel that risks of short- or long-term drug-related complications, nonadherence to lifelong therapy in asymptomatic patients, and potential for development of drug resistance may offset possible benefits of earlier initiation of therapy. Thus, pending more definitive supporting evidence, these Panel members recommend that therapy in this setting should be optional and considered on a case-by case basis. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. October 14, 2011;. Available at <a href="http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf">aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf</a> <sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP. <sup>4</sup> Gebo, JAIDS January 2005, vol. 38, pp. 96-103. <sup>5</sup> Teshale Abstract #167, CROI 2005. <sup>6</sup> The National HIVQUAL data may not be directly comparable due to varying exclusions. Indicator definitions can be accessed at <a href="http://www.hivguidelines.org/Content.aspx?PageID=53">http://www.hivguidelines.org/Content.aspx?PageID=53</a> .	

**FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**

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<sup>7</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

<b>Performance Measure 1.3:</b> Pneumocystis pneumonia (PCP) prophylaxis																									
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection and a CD4 T-cell count < 200 cells/mm <sup>3</sup> who were prescribed PCP prophylaxis in the measurement year.																									
<b>Numerator:</b>	Number of HIV-infected patients with CD4 T-cell count < 200 cells/mm <sup>3</sup> who were prescribed PCP prophylaxis <sup>2,3</sup> in the measurement year.																								
<b>Denominator:</b>	Number of HIV-infected patients who: <ul style="list-style-type: none"><li>• had a medical visit with a provider with prescribing privileges,<sup>4</sup> at least twice in the measurement year, and</li><li>• had a CD4 T-cell count &lt; 200 cells/mm<sup>3</sup></li></ul>																								
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"><li>1. Patients with CD4 T-cell count &lt; 200 cells/mm<sup>3</sup> repeated within three months rose above 200 cells/mm<sup>3</sup></li><li>2. Patients newly enrolled in care during last three months of the measurement year.</li><li>3. Patients with documented refusal to take PCP prophylaxis in medical record.</li></ol>																								
<b>Data Element:</b>	<ol style="list-style-type: none"><li>1. Is the patient HIV-infected? (Y/N)<ol style="list-style-type: none"><li>a. If yes, was the CD4 T-cell count &lt;200 cells/mm<sup>3</sup>? (Y/N)<ol style="list-style-type: none"><li>i. If yes, was PCP prophylaxis prescribed? (Y/N)<ol style="list-style-type: none"><li>1. If no, was the CD4 count repeated within three months? (Y/N)<ol style="list-style-type: none"><li>A. If yes, did it remain &lt; 200 cells/mm<sup>3</sup>? (Y/N)<ol style="list-style-type: none"><li>I. If yes, was PCP prophylaxis prescribed? (Y/N)</li></ol></li></ol></li></ol></li></ol></li></ol></li></ol>																								
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>• Electronic Medical Record/Electronic Health Record</li><li>• HIVQUAL reports on this measure for grantee under review</li><li>• CAREWare, Lab Tracker, or other electronic data base</li><li>• Medical record data abstraction by grantee of a sample of records</li></ul>																								
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	DHSP Benchmark: 95% IHI Goal: 95% <sup>5</sup> National HIVQUAL-US Data: <sup>6</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td></tr><tr><td>Top 10%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Top 25%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Median*</td><td>93.3%</td><td>90.9%</td><td>92.3%</td><td>94.4%</td></tr></table> *from HAB data base						2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	100%	100%	100%	100%	Median*	93.3%	90.9%	92.3%	94.4%
	2003	2004	2005	2006																					
Top 10%	100%	100%	100%	100%																					
Top 25%	100%	100%	100%	100%																					
Median*	93.3%	90.9%	92.3%	94.4%																					
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"><li>○ Rate of PCP in the measurement year</li><li>○ Mortality rates</li><li>○ Cost effectiveness</li></ul>																								

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**Basis for Selection:**

PCP is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV-infection, yet is almost entirely preventable and treatable. Pneumocystis almost always affects the lungs, causing a form of pneumonia. People with CD4 T-cell counts < 200 cells/mm<sup>3</sup> are at greatest risk of developing PCP.<sup>2</sup>

Before the widespread use of primary PCP prophylaxis and effective ART, PCP occurred in 70%-80% of patients with AIDS.<sup>7</sup> The course of treated PCP was associated with a mortality rate of between 20% and 40% in persons with profound immunosuppression. Approximately 90% of cases occurred among patients with CD4 T-cell counts <200 cells/mm<sup>3</sup>.<sup>8,9</sup> Measure reflects important aspect of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

**U.S. Public Health Service Guidelines:**

HIV-infected adults and adolescents, including pregnant women and those on ART, should receive chemoprophylaxis against PCP if they have a CD4 T-cell count <200 cells/mm<sup>3</sup> or a history of oropharyngeal candidiasis.<sup>2</sup>

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

<sup>3</sup> PCP prophylactic recommended in US PHS guidelines: TMP-SMX (preferred regimen at 1 DS QD, however tolerability may improve with 1 SS QD, 1 DS 3x a week), alternative regimens (in case of TMP-SMX intolerance) include: 1) dapsone + pyrimethamine + leukovorin; 2) atovaquone; 3) aerosolized pentamidine; 4) oral pyrimethamine + sulfadoxine (if sulfonamide hypersensitivity).

<sup>4</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP..

<sup>5</sup> IHI Measure reads, “Percent of Patients with a CD4 Cell Count Below 200 cells/mm<sup>3</sup> receiving Pneumocystis Carinii Pneumonia (PCP) Prophylaxis”

<sup>6</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

<sup>7</sup> Phair J, Munoz A, Detels R, et al. The risk of Pneumocystis carinii pneumonia among men infected with human immunodeficiency virus type 1. Multicenter AIDS Cohort Study Group. N Engl J Med 1990;322:161–5.

<sup>8</sup> Kaplan JE, Hanson DL, Navin TR, Jones JL. Risk factors for primary Pneumocystis carinii pneumonia in human immunodeficiency virus- infected adolescents and adults in the United States: reassessment of indications for chemoprophylaxis. J Infect Dis 1998;178:1126–32.

<sup>9</sup> Kaplan JE, Hanson DL, Jones JL, Dworkin MS. Viral load as an independent risk factor for opportunistic infections in HIV-infected adults and adolescents. AIDS 2001;15:1831–6.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

<b>Performance Measure 1.4:</b> Adherence assessment and counseling																									
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection on ART who were assessed for adherence (and counseled if suboptimal adherence) two or more times in the measurement year.																									
<b>Numerator:</b>	Number of HIV-infected patients, as part of their primary care, who were assessed for adherence and counseled (if suboptimal adherence) <sup>2,3</sup> two or more times in the measurement year.																								
<b>Denominator:</b>	Number of HIV-infected patients on ART who had a medical visit with a provider with prescribing privileges <sup>4</sup> at least twice in the measurement year																								
<b>Patient Exclusions:</b>	<div>1. Patients newly enrolled in care during the last six months of the measurement year.</div> <div>2. Patients who initiated ART during the last six months of the measurement year.</div>																								
<b>Data Element:</b>	<div>1. Is the patient HIV-infected? (Y/N)<div><div>a. If yes, was the patient on ART? (Y/N)<div><div>i. If the patient was on ART, did he/she receive adherence counseling during the measurement year? (Y/N)<div><div>1. If yes, list the dates of these visits</div></div></div></div></div></div></div>																								
<b>Data Sources:</b>	<div><div>• Electronic Medical Record/Electronic Health Record</div><div>• HIVQUAL reports on this measure for grantee under review</div><div>• CAREWare, Lab Tracker, or other electronic data base</div><div>• Medical record data abstraction by grantee of a sample of records</div></div>																								
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<div>DHSP Benchmark: 95%</div> <div>IHI Goal: 90%<sup>5</sup></div> <div>National HIVQUAL-US Performance Data:<sup>6</sup><table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td></tr><tr><td>Top 10%</td><td>95.8%</td><td>92.0%</td><td>97.5%</td><td>98.4%</td></tr><tr><td>Top 25%</td><td>82.7%</td><td>79.2%</td><td>88.3%</td><td>91.6%</td></tr><tr><td>Median*</td><td>57.5%</td><td>39.7%</td><td>46.8%</td><td>55.7%</td></tr></table></div> <div>*from HAB data base</div>						2003	2004	2005	2006	Top 10%	95.8%	92.0%	97.5%	98.4%	Top 25%	82.7%	79.2%	88.3%	91.6%	Median*	57.5%	39.7%	46.8%	55.7%
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Median*	57.5%	39.7%	46.8%	55.7%																					
<b>Outcome Measures for Consideration:</b>	<div><div>○ Percent of undetectable viral loads among patients on ART in the measurement year</div><div>○ Percent of patients with ART-resistance developed during therapy in the measurement year</div><div>○ Mortality rates</div><div>○ Incidence of HIV-related hospitalizations in the clinic population</div><div>○ Incidence of patients with progression to AIDS in the clinic population</div></div>																								

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**Basis for Selection:**

Adherence is a key determinant in the degree and duration of virologic suppression. Among studies reporting on the association between suboptimal adherence and virologic failure, non-adherence among patients on ART was the strongest predictor for failure to achieve viral suppression below the level of detection. HIV viral suppression, reduced rates of resistance, and improved survival have been correlated with high rates of adherence to ART.<sup>7</sup>

Prior to writing the first prescriptions, clinicians need to assess the patient's readiness to take medication. Patients need to understand that the first regimen is the best chance for long-term success. Resources need to be identified to assist in success. Interventions can also assist with identifying adherence education needs and strategies for each patient."<sup>7</sup>

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Although discussions of the importance of adherence to ART are important to begin prior to initiation of treatment, there is no standard of care for discussions to occur every six months for patients who may be years away from antiretroviral treatment.

**U.S. Public Health Guidelines:**

"...adherence counseling and assessment should be done at each clinical encounter"<sup>7</sup>

**References/Notes:**

<sup>1</sup> "Patients" include all patients aged 13 years or older.

<sup>2</sup> Assessment of adherence includes: 1) patient reports of adherence by: a) quantifiable scales, e.g. missed three out of ten doses; b) qualitative scale, e.g. Likert scale; or 2) quantification such as pharmacy dispensing records, pill counts, or direct observation therapy.

<sup>3</sup> Adherence assessment should be provided by the provider with prescribing privileges. Adherence counseling should be performed for patients who report suboptimal adherence (less than 100% no missed doses). Counseling can be provided by any member of the multidisciplinary primary care team.

<sup>4</sup> A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP..

<sup>5</sup> IHI Measure reads, "Percent of Patients/Patients Assessed for Adherence to Antiretroviral (ARV) Therapy in the Past 4 Months."

<http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientsAssessedforAdherencetoAntiretroviralARVTherapyinthePast4Months.htm>.

<sup>6</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

<sup>7</sup> Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.5: Cervical cancer screening							
Description: Percentage of women with HIV infection who have a PAP screen in the measurement year.							
Numerator:	Number of HIV-infected female patients <sup>1</sup> who had PAP screen results documented in the measurement year.						
Denominator:	Number of HIV-infected female patients who: <ul style="list-style-type: none"><li>were <math>\geq 18</math> years old<sup>2</sup> in the measurement year or reported having a history of sexual activity, and</li><li>had a medical visit with a provider with prescribing privileges<sup>3</sup> at least twice in the measurement year</li></ul>						
Patient Exclusions:	<ol style="list-style-type: none"><li>Patients who were &lt; 18 years old and denied history of sexual activity.</li><li>Patients who have had a hysterectomy for non-dysplasia/non-malignant indications.</li><li>Patients with documented refusal of PAP screen in medical record.</li></ol>						
Data Element:	<ol style="list-style-type: none"><li>Is the patient HIV-infected? (Y/N)<ol style="list-style-type: none"><li>If yes, is the patient female? (Y/N)<ol style="list-style-type: none"><li>If yes, is she <math>\geq 18</math> years or reports having a history of sexual activity? (Y/N)</li></ol></li><li>If yes, was the PAP screening completed during the measurement year?</li></ol></li></ol>						
Data Sources:	<ul style="list-style-type: none"><li>Ryan White Program Data Report, Section 5, Items 42 and 52 may provide data useful in establishing a baseline for this performance measure</li><li>Electronic Medical Record/Electronic Health Record</li><li>CAREWare, Lab Tracker, or other electronic data base</li><li>HIVQUAL reports on this measure for grantee under review</li><li>Medical record data abstraction by grantee of a sample of records</li></ul>						
National Goals, Targets, or Benchmarks for Comparison	DHSP Benchmark: 90%						
	IHI Goal: 90% <sup>4</sup>						
	National HIVQUAL-US Data: <sup>5</sup>						
	Percent of female patients who received a pelvic examination.						
		2003	2004	2005	2006	2007	2009
	Top 10%	100%	100%	100%	100%	100%	94.1%
	Top 25%	84.3%	86.7%	87.0%	89.2%	n/a	
Median*	70.5%	67.7%	71.8%	73.3%	70.0%	66.7%	
Bottom 10%					45.5%	33.3%	
*from HAB data base							
Percent of female patients who received a pelvic examination and Pap test							

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

		2007	2009
	Top 10%	100%	90.9%
	Median	67.1%	62.1%
	Bottom 10%	43.5%	31.6%
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Incidence of cervical cancer in HIV-positive women in clinic population</li> </ul>		

**Basis for Selection:**

Human Papillomavirus (HPV) is a common infection in the general population. Current evidence suggests that over 50% of sexually active adults have been infected with one or more HPV types. According to population-based prospective studies, HPV precedes the development of cervical cancer.<sup>6</sup>

The American College of Obstetricians and Gynecologists (ACOG) identifies additional risk factors that might justify annual screening, including a history of cervical neoplasia, infection with HPV or other sexually transmitted diseases (STDs), or high-risk sexual behavior, but data are limited to determine the benefits of these strategies.<sup>7</sup>

Cervical cancer may be the most common AIDS-related malignancy in women. Although not a common diagnosis in women in the general population, according to New York City AIDS Surveillance data from 1990 to 1995, the observed cervical cancer cases in HIV-positive women were two to three times higher than the expected number of cases.<sup>8</sup> Findings such as these resulted in the inclusion of cervical cancer in the Centers for Disease Control and Prevention (CDC) expanded definition of AIDS.<sup>9</sup>

When compared with HIV-negative women, HIV-positive women with invasive cervical cancer present at more advanced stages and with cancer metastasizing to unusual locations. HIV-positive women have poorer responses to standard therapy and have higher recurrences and death rates, as well as shorter intervals to recurrence or death.<sup>10,11</sup>

The CDC currently recommends that HIV-positive women have a complete gynecologic evaluation, including a PAP smear, as part of their initial HIV evaluations, or upon entry to prenatal care, and another PAP smear six months later. If both PAP smears are negative, annual screening is recommended thereafter in asymptomatic women. The CDC further recommends more frequent screenings (every six months) for women with symptomatic HIV-infection, prior abnormal PAP smears, or signs of HPV infection.<sup>12,13</sup>

Cervical cancer can often be prevented or detected in its earliest stages through effective screening with a PAP smear and avoidance of known risk factors. This accentuates the importance of routine gynecological care, which includes PAP smears for HIV-infected women.<sup>14</sup> Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

**U.S. Public Health Guidelines:**

“The Pap test should be obtained twice during the first year after diagnosis of HIV-infection and, if the results are normal, annually thereafter (AII). If the results of the Pap test are abnormal, care should be provided according to the Guidelines for Management of Women with

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

Abnormal Cervical Cancer Screening Tests by ASCCP.”<sup>15</sup>

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Onset of sexual activity is not reliably reported or recorded. The age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> **Goal:** Greater than 90 percent of female patients/clients will have a documented Pap test in the past 12 months.

<http://www.ihl.org/knowledge/Pages/Measures/PercentofFemalePatientsClientswithanAnnualPapicolaouPapTest.aspx>

<sup>5</sup> National HIVQUAL data looked at the percent of female patients who have an annual pelvic exam until 2007, when pelvic exam and Pap examination among female patients was added. Data was not collect data in 2008. HIVQUAL-US Performance Data Report, Ryan White Part C and Part D Funded Programs, Review Period: January 1, 2009 – December 31, 2009. Available at: <http://hivqualus.org/index.cfm/8418/10039>

<sup>6</sup> Davis, AT. Cervical dysplasia in women infected with the human immunodeficiency virus (HIV): A correlation with HIV viral load and CD4 count. Gynecologic Oncology. 2001; 80(3):350–354.

<sup>7</sup> Guide to Clinical Preventive Services, 2010-2011, Recommendations of the U.S. Preventive Services Task Force, p 47

<http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf> Available at:

<http://www.ahrq.gov/clinic/pocketgd.htm>

<sup>8</sup> Chiasson, MA. Declining AIDS mortality in New York City. New York City Department of Health. Bull NY Acad. Med. 1997; 74:151–152.

<sup>9</sup> Centers for Disease Control and Prevention (CDC). 1993. Revised classification system for HIV-infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR. 1992; 41(RR-17).

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm>.

<sup>10</sup> Ibid.

<sup>11</sup> U.S. Department of Health and Human Services. Anderson, JA, editor. Guide to the Clinical Care of Women with HIV; 2005.

<sup>12</sup> National Institutes of Allergy and Infectious Diseases. HIV Infection in Women <http://www.niaid.nih.gov/topics/hivaids/understanding/population%20specific%20information/pages/womenhiv.aspx>. Accessed 3/123/2012 <sup>13</sup>. Susan Richardson, MN, MPH, FNP-BC. Health Care of HIV-Infected Women Through the Life Cycle, in Guide for HIV/AIDS Clinical Care. U.S. Department of Health and Human Services, Health Resources and Services Administration HIV/AIDS Bureau, January 2011 <http://hab.hrsa.gov/deliverhivaidscares/clinicalguide11/>

<sup>14</sup> Kjaer, S. Type specific persistence of high risk human papillomavirus (HPV) as indicator of high grade cervical squamous intraepithelial lesions in young women: population based prospective follow-up study, Brit Med J. 2002; 325: 572–578.

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<sup>15</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2009;58(No. RR-4)  
[http://aidsinfo.nih.gov/contentfiles/Adult\\_OI\\_041009.pdf](http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009.pdf)

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

<b>Performance Measure 1.6:</b> Hepatitis C (HCV) screening																									
<b>Description:</b> Percentage of patients <sup>1</sup> for whom HCV screening was performed at least once since the diagnosis of HIV-infection in the measurement year.																									
<b>Numerator:</b>	Number of HIV-infected patients who have HCV status documented in chart since HIV diagnosis or initiation of care with provider <sup>2</sup>																								
<b>Denominator:</b>	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year																								
<b>Patient Exclusions:</b>	1. Patient refusal of test.																								
<b>Data Element:</b>	1. Is the patient HIV-infected? (Y/N) a. If yes, is there documentation of the patient’s Hepatitis C status (Hepatitis C Antibody positive or negative) in the medical record? (Y/N)																								
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>• Ryan White Program Data Report, Section 5, Items 42 and 48 may provide data useful in establishing a baseline for this performance measure</li><li>• Electronic Medical Record/Electronic Health Record</li><li>• CAREWare, Lab Tracker, or other electronic data base</li><li>• HIVQUAL reports on this measure for grantee under review</li><li>• Medical record data abstraction by grantee of a sample of records</li></ul>																								
<b>National Goals, Targets, or Benchmarks for Comparison</b>	DHSP Benchmark: 90% IHI Goal: 95% <sup>4</sup> National HIVQUAL-US Performance Data: <sup>5</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td></tr><tr><td>Top 10%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Top 25%</td><td>94.4%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Median*</td><td>86.2%</td><td>88.8%</td><td>90.5%</td><td>90.9%</td></tr></table> *from HAB data base						2003	2004	2005	2006	Top 10%	100%	100%	100%	100%	Top 25%	94.4%	100%	100%	100%	Median*	86.2%	88.8%	90.5%	90.9%
	2003	2004	2005	2006																					
Top 10%	100%	100%	100%	100%																					
Top 25%	94.4%	100%	100%	100%																					
Median*	86.2%	88.8%	90.5%	90.9%																					
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"><li>○ Hepatitis C- related mortality rates in the clinic population</li></ul>																								
<b>Basis for Selection:</b>																									
Approximately 15% to 30% of people with HIV are estimated to be co-infected with hepatitis C virus (HCV) in the United States, and up to 90% of those with HIV secondary to injection drug use are co-infected. Chronic liver disease from co-infection, including cirrhosis and hepatocellular carcinoma, leads to significant morbidity and mortality <sup>6</sup> and HCV treatment may exacerbate the side effects of some antiretroviral medications. <sup>7</sup>																									
Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base																									

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supporting the use.

**U.S. Public Health Guidelines:**

“HIV-infected patients should be tested routinely for evidence of chronic HCV infection”<sup>8</sup>  
(3/29/09)

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Unless there is concern about ongoing exposure (e.g., via active injection drug use or sexual exposure), guidelines do not consistently recommend annual re-screening.

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> IHI Measure reads, “Percent of Patients/Patients with Known Hepatitis C Status”  
<http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientswithKnownHepatitisCStatus.htm>.

<sup>5</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

<sup>6</sup> Medscape: HIV and Hepatitis C Co-infection: Guideline and Commentary, Douglas G. Fish, MD <http://www.medscape.com/viewarticle/734975>

<sup>7</sup> Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011; 1–167. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

<sup>8</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.  
<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

<b>Performance Measure 1.7: HIV risk counseling</b>	
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who received HIV risk counseling <sup>2</sup> within the measurement year.	
<b>Numerator:</b>	Number of HIV-infected patients, as part of their primary care, who received HIV risk counseling within the measurement year.
<b>Denominator:</b>	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year
<b>Patient Exclusions:</b>	None.
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> <li>a. If yes, did the patient receive HIV risk counseling at least once during the measurement year with appropriate feedback to the provider?(Y/N)</li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<p>DHSP Benchmark: 95%</p> <p>None available at this time</p>
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"> <li>○ Incidence of new HIV-infection</li> <li>○ Incidence of STD cases in clinic population</li> <li>○ Rates of substance abuse counseling and referrals</li> </ul>
<b>Basis for Selection:</b>	
<p>Reducing transmission of HIV in the United States requires new strategies, including emphasis on prevention of transmission by HIV-infected persons. Through ongoing attention to prevention, risky sexual and needle sharing behaviors among persons with HIV-infection can be reduced, and transmission of HIV-infection prevented. Medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors; communicating prevention messages; discussing sexual and drug-use behavior; positively reinforcing changes to safer behavior; referring patients for services such as substance abuse treatment; facilitating partner notification, counseling, and testing; and identifying and treating other sexually transmitted diseases.<sup>4</sup></p> <p>Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.</p>	
<b>U.S. Public Health Guidelines:</b>	
<p>"HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and</p>	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks."<sup>4,5</sup>

### References/Notes:

<sup>1</sup> "Patients" include all patients aged 13 years or older.

<sup>2</sup> HIV risk counseling includes assessment of risk, counseling, and as necessary, referrals. Counseling occurs in the context of comprehensive medical care and can be provided by any member of the multidisciplinary primary care team.

<sup>3</sup> A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> Centers for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2003;52 (No. RR-12).

<http://www.cdc.gov/mmwr/PDF/rr/rr5212.pdf> or

[http://aidsinfo.nih.gov/ContentFiles/HIVPreventionInMedCare\\_TB.pdf](http://aidsinfo.nih.gov/ContentFiles/HIVPreventionInMedCare_TB.pdf).

<sup>5</sup> Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011 <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

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### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

Performance Measure 1.8: Syphilis screening																									
<b>Description:</b> Percentage of adult patients <sup>1</sup> with HIV infection who had a test for syphilis performed within the measurement year.																									
<b>Numerator:</b>	Number of HIV-infected patients who had a serologic test for syphilis performed at least once during the measurement year.																								
<b>Denominator:</b>	Number of HIV-infected patients who: <ul style="list-style-type: none"><li>were <math>\geq 18</math> years old in the measurement year<sup>2</sup> or had a history of sexual activity <math>&lt; 18</math> years, and</li><li>had a medical visit with a provider with prescribing privileges<sup>3</sup> at least twice in the measurement year</li></ul>																								
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"><li>Patients who were <math>&lt; 18</math> years old and denied a history of sexual activity.</li><li>Patient refusal of test.</li></ol>																								
<b>Data Element:</b>	<ol style="list-style-type: none"><li>Is the patient HIV-infected? (Y/N)<ol style="list-style-type: none"><li>If yes, is the patient <math>\geq 18</math> years or reports having a history of sexual activity? (Y/N)<ol style="list-style-type: none"><li>If yes, was the patient screened for syphilis with Nontreponemal test (RPR, VDRL) during the measurement year?</li><li>If Nontreponemal test was positive, was confirmatory Treponemal test performed (Treponemal tests include: fluorescent Treponemal antibody absorption (FTA-ABS) test, the microhemagglutination test for antibodies to Treponema pallidum (MHA-TP), or the Treponema pallidum particle agglutination assay (TPPA)).</li></ol></li></ol></li></ol>																								
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>Ryan White Program Data Report, Section 5, Items 42 and 48 may provide data useful in establishing a baseline for this performance measure</li><li>Electronic Medical Record/Electronic Health Record</li><li>CAREWare, Lab Tracker, or other electronic data base</li><li>HIVQUAL reports on this measure for grantee under review</li><li>Medical record data abstraction by grantee of a sample of records</li></ul>																								
<b>National Goals, Targets, or Benchmarks for Comparison</b>	DHSP Benchmark: 90% IHI Goal: 90% <sup>4</sup> National HIVQUAL-US Data: <sup>5</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td></tr><tr><td>Top 10%</td><td>99.0%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Top 25%</td><td>90.4%</td><td>92.2%</td><td>95.7%</td><td>95.6%</td></tr><tr><td>Median*</td><td>73.7%</td><td>78.5%</td><td>82.1%</td><td>80.0%</td></tr></table> *from HAB data base						2003	2004	2005	2006	Top 10%	99.0%	100%	100%	100%	Top 25%	90.4%	92.2%	95.7%	95.6%	Median*	73.7%	78.5%	82.1%	80.0%
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Median*	73.7%	78.5%	82.1%	80.0%																					

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<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Incidence of syphilis in the clinic population</li> </ul>
<b>Basis for Selection:</b>	
<p>HIV-1 infection appears to alter the diagnosis, natural history, management, and outcome of <i>T. pallidum</i> infection. Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use. Because the incidence of some STDs, notably syphilis, is higher in HIV-infected persons, the use of client-centered STD counseling for HIV-infected persons has been strongly encouraged by public health agencies and other health organizations. Consensus guidelines issued by CDC, the Health Resources and Services Administration, the HIV Medicine Association of the Infectious Diseases Society of America, and the National Institutes of Health emphasize that STD/HIV risk assessment, STD screening, and client-centered risk reduction counseling should be provided routinely to HIV-infected persons.<sup>6</sup></p>	
<p><b>Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America</b></p> <p>Routine laboratory screening for syphilis is indicated for all sexually active MSM. Screening tests should be performed at least annually for sexually active MSM.</p> <p>Serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. Because many STDs are asymptomatic, routine screening for curable STDs (e.g., syphilis) should be performed at least annually for all sexually active, HIV-positive persons.<sup>6</sup></p> <p>The resurgence of syphilis among persons with HIV infection in the United States underscores the importance of primary prevention of syphilis among persons with HIV infection. This should begin with routine discussion of sexual behaviors. Providers should discuss client-centered risk reduction messages and provide specific actions that can reduce the risk for acquiring sexually transmitted infections and for transmitting HIV. Routine serologic screening for syphilis is recommended at least annually for all sexually active HIV-infected persons, with more frequent screening (every 3--6 months) for those with multiple partners, unprotected intercourse, sex in conjunction with illicit drug use, methamphetamine use, or partners who participate in such activities. The occurrence of syphilis in an HIV-infected person is an indication of high-risk behavior and should prompt intensified counseling messages and strong consideration of referral for behavioral intervention. Persons undergoing screening or treatment for syphilis also should be evaluated for all common sexually transmitted diseases (STDs).<sup>7</sup></p>	
<b>References/Notes:</b>	
<p><sup>1</sup>“Patients” include all patients aged 13 years or older.</p> <p><sup>2</sup> Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.</p> <p><sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.</p> <p><sup>4</sup> IHI Measure reads, “Percent of Patients with Annual Syphilis Screen”</p>	

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(<http://www.ihl.org/IHI/Topics/HIV/AIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithAnnualSyphilisScreen.htm>)

<sup>5</sup> ([http://www.hivguidelines.org/public\\_html/center/quality-of-care/hivqual-project/hivqual-workshop/03-04-natl-score-top10-25.pdf](http://www.hivguidelines.org/public_html/center/quality-of-care/hivqual-project/hivqual-workshop/03-04-natl-score-top10-25.pdf))

<sup>6</sup> Morbidity and Mortality Weekly Report December 17, 2010 Volume 59

<sup>7</sup> Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents March 24, 2009

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### Clinical Performance Measures for Adult/Adolescent Patients: Core Measures

<b>Performance Measure 1.9:</b> Tuberculosis screening																									
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who received testing with results documented for latent tuberculosis infection (LTBI) in the measurement year.																									
<b>Numerator:</b>	Number of patients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis.																								
<b>Denominator:</b>	Number of HIV-infected patients who: <ul style="list-style-type: none"><li>do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA<sup>2</sup>; and</li><li>had a medical visit with a provider with prescribing privileges<sup>3</sup> at least twice in the measurement year.</li></ul>																								
<b>Patient Exclusions</b>	1. Patient refusal of TST or IGRA <sup>4</sup>																								
<b>Data Element:</b>	1. Is the patient HIV-infected? (Y/N) <ul style="list-style-type: none"><li>a. If yes, has the patient ever had previous documented culture-positive TB disease or previous documented positive TST or IGRA? (Y/N)<ul style="list-style-type: none"><li>i. If no, has the patient been tested for LTBI with a TST or IGRA in the measurement year? (Y/N)<ul style="list-style-type: none"><li>1. If yes, are the results documented? (Y/N)</li></ul></li></ul></li></ul>																								
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>Ryan White Program Data Report, Section 5, Item 47 may provide data useful in establishing a baseline for this performance measure</li><li>Electronic Medical Record/Electronic Health Record</li><li>CAREWare, Lab Tracker, or other electronic data base</li><li>HIVQUAL reports on this measure for grantee under review</li><li>Medical record data abstraction by grantee of a sample of records</li></ul>																								
<b>National Goals, Targets, or Benchmarks for Comparison</b>	DHSP Benchmark: 75% National HIVQUAL-US Data: <sup>5</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td></tr><tr><td>Top 10%</td><td>88.9%</td><td>91.7%</td><td>88.8%</td><td>92.2%</td></tr><tr><td>Top 25%</td><td>77.4%</td><td>73.5%</td><td>74.8%</td><td>78.2%</td></tr><tr><td>Median*</td><td>58.8%</td><td>56.0%</td><td>57.1%</td><td>56.2%</td></tr></table> *from HAB data base						2003	2004	2005	2006	Top 10%	88.9%	91.7%	88.8%	92.2%	Top 25%	77.4%	73.5%	74.8%	78.2%	Median*	58.8%	56.0%	57.1%	56.2%
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Median*	58.8%	56.0%	57.1%	56.2%																					
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"><li>Incidence of TB disease in the clinic population</li></ul>																								

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**Basis for Selection:**

HIV is the most important known risk factor for progression to TB disease from LTBI after exposure to infectious TB patients. There is a 2% to 8% TB risk per year within five years after LTBI for HIV-infected adults<sup>6,7</sup> versus an 8% TB risk over 60 years for adults with LTBI but not HIV.<sup>8</sup> The TB risk for HIV-infected persons remains higher than for HIV-uninfected persons, even for HIV-infected persons who are taking antiretroviral medications.<sup>9,10</sup> TB disease is an AIDS-defining opportunistic condition that can be deadly. McCombs found a three-times adjusted odds of being diagnosed with TB at death and a five times adjusted odds of dying during TB treatment for HIV-infected TB patients compared with other patients from 1993 through 2001.<sup>11</sup>

Immunologic and virologic evidence now indicates that the host immune response to *M. tuberculosis* enhances HIV replication and might accelerate the natural progression of HIV-infection.<sup>12</sup>

Providers should screen all HIV-infected patients for TB and LTBI as soon as possible after HIV diagnosis. TB and LTBI testing should be conducted among HIV-infected persons regardless of duration of infection since they are at increased risk for progressing to TB disease. Thus, an HIV-infected person having a prior positive TST for which he/she did not complete treatment is still eligible for treatment. However, early identification and treatment of TB disease improves outcomes and reduces the risk of transmission. TB should be suspected in any patient who has had a persistent cough for more than two to three weeks, especially if the patient has at least one additional symptom, including fever, night sweats (sufficient to require changing of bed clothes or sheets), weight loss, or hemoptysis (coughing up blood).

Identification of LTBI and completion of LTBI treatment reduces the risk of development of TB disease by 70 to 90 percent.<sup>13</sup>

Measure reflects important aspect of care that impacts HIV-related morbidity and mortality and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.

**U.S. Public Health Guidelines:**

Guidelines for TB services for HIV-infected persons, such as those jointly published by the PHS and the Infectious Diseases Society of America<sup>14</sup> or by the Centers for Disease Control and Prevention (CDC)<sup>15</sup> call for:

- provision of a TST or IGRA when HIV-infection is first recognized,
- annual TST or IGRA for HIV-infected persons who are initially TST-negative and belong to groups at substantial risk for TB exposure or if they experience immune reconstitution,
- chest radiographs and clinical evaluations to rule out active TB among those who are TST positive (reactions  $\geq 5$  mm) or who have symptoms (regardless of TST result), and
- LTBI treatment (once active TB has been excluded) for those having a positive TST/IGRA or for those who are recent contacts of persons with infectious active TB.<sup>16</sup>

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Previous documented culture-positive TB disease or previous documented positive TST or IGRA occurred prior to HIV diagnosis.

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<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> History of receiving BCG is NOT an exclusion to receiving TST. See: Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection. MMWR, 2000/49(RR06);1-64.

<sup>5</sup> “PPD screening.”

<http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>

<sup>6</sup> Markowitz N, Hansen NI, Hopewell PC, et al. Incidence of tuberculosis in the United States among HIV-infected persons. *Annals of Internal Medicine*. 1997;126:123-32.

<sup>7</sup> Selwyn PA, Hartel D, Lewis VA, et al. A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. *New England Journal of Medicine*. 1989;320:545-50.

<sup>8</sup> Aronson NE, Santosham M, Comstock GW, et al. Long-term efficacy of BCG vaccine in American Indians and Alaska Natives: A 60-year follow-up study. *Journal of the American Medical Association*. 2004;291(17):2086-91.

<sup>9</sup> The Antiretroviral therapy cohort collaboration. Incidence of tuberculosis among HIV-infected patients receiving highly active antiretroviral therapy in Europe and North America. *Clinical Infectious Diseases*. 2005;41:1772-1782.

<sup>10</sup> Jones JL, Hanson DL, Dworkin MS, DeCock KM, and the Adult/Adolescent Spectrum of HIV Disease Group. HIV-associated tuberculosis in the era of highly active antiretroviral therapy. *International Journal of TB and Lung Disease*. 2000;4(11):1026-1031.

<sup>11</sup> McCombs SB. Tuberculosis mortality in the United States, 1993-2001. Oral presentation at CDC. Atlanta. December 2003.

<sup>12</sup> Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. MMWR 1998 Oct 30; 47(RR-20):1-58.

<sup>13</sup> American Thoracic Society/Centers for Diseases Control and Prevention/Infectious Diseases Society of America. Treatment of tuberculosis. *Am J Respir Crit Care Med* 2003;167:603-662

<sup>14</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.

<http://www.aidsinfo.nih.gov/Guidelines>

<sup>15</sup> Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. MMWR 1998 Oct 30; 47(RR-20):1-58.

<sup>16</sup> Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR December 16, 2005 / Vol. 54 / No. RR-15.

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### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.1: Chlamydia screen</b>	
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who had a test for Chlamydia <sup>2</sup> within the measurement year.	
<b>Numerator:</b>	Number of HIV-infected patients who received a test for Chlamydia in the measurement year.
<b>Denominator:</b>	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patient refusal of test, documented in medical record.</li> <li>2. Patients who are &lt;18 yrs of age<sup>4</sup> and deny a history of sexual activity.</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-positive? (Y/N)               <ol style="list-style-type: none"> <li>a. If yes, is the patient &gt; 18 years or sexually active? (Y/N)                   <ol style="list-style-type: none"> <li>i. If yes, was the patient tested for urethral, rectal and/or cervical Chlamydia during the measurement period? (Y/N)</li> </ol> </li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic</li> <li>• Medical record data abstraction by grantee of a sample of records.</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	DHSP Benchmark: 90% None available at this time.
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Incidence of Chlamydia in the clinic population</li> <li>○ Incidence of pelvic inflammatory disease in the clinic population</li> </ul>
<b>Basis for Selection:</b>	
<p>Early detection and treatment of STDs may reduce the risk for STD and HIV transmission. Providers should screen for STD's to treat infections and decrease HIV transmission to sexual partners. Many STD's increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV-infection.<sup>5</sup> STD's can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.<sup>6,7</sup></p> <p>STD infections in seronegative partners increase the risk for acquiring HIV because they increase of the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.<sup>8</sup> Susceptibility to transmission may therefore be enhanced. Chlamydia infection in women may often be asymptomatic but like other STD's can also increase the risk for HIV transmission and enhance transmission susceptibility. Providers should test women for Chlamydia infection at least annually to treat infections and to decrease the risk of Chlamydia and HIV transmission. Identification and treatment of STD's can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks).<sup>7</sup></p>	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**U.S. Public Health Guidelines:**

“During the first visit, consider testing all patients for urogenital chlamydial infection. For subsequent routine visits, repeated tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk.”<sup>7</sup>

**References/Notes:**

<sup>1</sup> “Patients” include all patients aged 13 years or older.

<sup>2</sup> Vaginal screening is the preferred Chlamydia test for women. Chlamydia screening for men should be site specific using the following guidelines: (a) rectal screening test for men reporting receptive anal sex in the past year; and (b) urine screening test for men reporting insertive only sex in the past year. The preferred method of Chlamydia testing currently is the molecular test also known as nucleic acid amplification tests (NAAT). Other methods that may be used include direct fluorescent antibody stain (DFA), which detects chlamydia antigens, and DNA probe, another test that looks for chlamydia DNA but is less sensitive than NAAT. Testing for *Neisseria gonorrhoeae* (gonorrhea) and *Chlamydia trachomatis* is generally done simultaneously as the two organisms have similar clinical presentations.

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

<sup>5</sup> Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet*

1998;351(suppl 3):5--7

<sup>6</sup> Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 2004 Oct 21;18(15):2075-9

<sup>7</sup> CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24

<sup>8</sup> DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV-infection, *Sex Transm Infect* **75** (1999), pp. 3–17.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.2:</b> Gonorrhea screen	
<b>Description:</b> Percentage of adult patients <sup>1</sup> with HIV infection who had a test for Gonorrhea <sup>2</sup> within the measurement year.	
<b>Numerator:</b>	Number of HIV-infected patients who received a test for Gonorrhea in the measurement year.
<b>Denominator:</b>	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patient refusal of test, documented in medical record.</li> <li>2. Patients who are &lt;18 yrs of age<sup>4</sup> and deny a history of sexual activity.</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-positive? (Y/N)               <ol style="list-style-type: none"> <li>a. If yes, is the patient &gt;18 years or sexually active? (Y/N)                   <ol style="list-style-type: none"> <li>i. If yes, was the patient screened for urethral, rectal and/or cervical gonorrhea during the reporting period? (Y/N)</li> </ol> </li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic</li> <li>• Medical record data abstraction by grantee of a sample of records.</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<p>DHSP Benchmark: 90%</p> <p>None available at this time.</p>
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Incidence of gonorrhea in the clinic population</li> <li>○ Incidence of pelvic inflammatory disease in the clinic population</li> </ul>
<b>Basis for Selection:</b>	
<p>Early detection and treatment of STDs may reduce the risk for STD and HIV transmission. Providers should screen for STDs to treat infections and decrease HIV transmission to sexual partners. Many STDs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV-infection.<sup>5</sup> STDs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.<sup>6</sup></p> <p>STD infections in seronegative partners increase the risk for acquiring HIV because they increase the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.<sup>6</sup> Susceptibility to transmission may therefore be enhanced.</p> <p>Identification and treatment of STDs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks.<sup>7</sup> There are currently no guidelines that delineate annual testing.</p>	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**U.S. Public Health Guidelines:**

“During the first visit, consider testing all patients for urogenital gonorrhea. For subsequent routine visits, repeated tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk.”<sup>8</sup>

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Vaginal screening is the preferred Gonorrhea test for women. Gonorrhea screening for men should be site specific using the following guidelines: (a) rectal screening test for men reporting receptive anal sex in the past year; (b) urine screening test for men reporting insertive only sex in the past year; and (c) pharyngeal screening test for men reporting receptive oral sex in the past year. The preferred method of Gonorrhea testing currently is the molecular test also known as nucleic acid amplification tests (NAAT). Other methods that may be used include direct fluorescent antibody stain (DFA), which detects [antigens](#), and DNA probe, another test that looks for DNA but is less sensitive than NAAT. Testing for *Neisseria gonorrhoeae* (gonorrhea) and *Chlamydia trachomatis* is generally done simultaneously as the two organisms have similar clinical presentations.

<sup>3</sup> Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.

<sup>4</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>5</sup> Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet*

1998;351(suppl 3):5--7

<sup>6</sup> Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS*. 2004 Oct 21;18(15):2075-9

<sup>7</sup> DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV-infection, *Sex Transm Infect* **75** (1999), pp. 3–17.

<sup>8</sup> CDC. Recommendations and Reports: “Incorporating HIV Prevention into the Medical Care of Persons Living with HIV”. July 18, 2003/52(RR12);1-24.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

Performance Measure 2.3: Pneumococcal vaccination																
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who have received a pneumococcal vaccination within the last 5 years.																
<b>Numerator:</b>	Number of patients who have received a pneumococcal vaccination within the last 5 years.															
<b>Denominator:</b>	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges <sup>2</sup> at least twice in the measurement year.															
<b>Patient Exclusion:</b>	<div>1. Patients with documented refusal of pneumococcal vaccine.</div> <div>2. Patients with hypersensitivity to pneumococcal vaccine or its components.</div>															
<b>Data Element:</b>	<div>1. Is the patient HIV-positive? (Y/N)</div> <div><div>a. If yes, is there documentation in the chart that the patient received the pneumococcal vaccine within the past five years? (Y/N)</div><div>b. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of pneumococcal vaccine in medical record in past five years</div></div>															
<b>Data Sources:</b>	<div><div>• Electronic Medical Record/Electronic Health Record</div><div>• CAREWare, Lab Tracker, or other electronic data base</div><div>• HIVQUAL reports on this measure for grantee under review</div><div>• Medical record data abstraction by grantee of a sample of records</div></div>															
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<div>DHSP Benchmark: 90%</div> <div>National HIVQUAL-US Data:<sup>3</sup></div> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td></tr><tr><td>Top 10%</td><td>97.7%</td><td>95.8%</td><td>97.5%</td></tr><tr><td>Top 25%</td><td>92.4%</td><td>90.1%</td><td>93.0%</td></tr></table> <div>*from HAB data base</div>					2003	2004	2005	Top 10%	97.7%	95.8%	97.5%	Top 25%	92.4%	90.1%	93.0%
	2003	2004	2005													
Top 10%	97.7%	95.8%	97.5%													
Top 25%	92.4%	90.1%	93.0%													
<b>Outcome Measures for Consideration</b>	<div><div>○ Incidence of pneumococcal infection in clinical population</div></div>															
<b>Basis for Selection:</b>																
Bacterial pneumonia is a common cause of HIV-1 related morbidity. Incidence of approximately 100 cases per 1,000 HIV-1 infected persons per year have been reported, a rate much higher than in the non-infected population. The most consistent predictor of bacterial infections is CD4 cell count. <sup>4</sup>																

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**U.S. Public Health Guidelines:**

“Adults and adolescents who have a CD4+ T-lymphocyte count of  $> 200$  cells/ $\mu$ L should be administered a single dose of 23-valent polysaccharide pneumococcal vaccine (PPV) if they have not received this vaccine during the previous five years (BII)”. Revaccination can be considered for patients who were initially immunized when their CD4+ T-lymphocyte counts were  $< 200$  cells/ $\mu$ L in response to ART (CIII).<sup>5</sup>

“If earlier vaccination status is unknown, patients in this group [immunocompromised, including HIV] should be administered pneumococcal vaccine.”<sup>6</sup>

**References/Notes:**

<sup>1</sup> “Patients” include all patients aged 13 years or older.

<sup>2</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>3</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

<sup>4</sup> Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004;53(No. RR-15).

<sup>5</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. April 10, 2009,58.  
<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

<sup>6</sup> Centers for Disease Control and Prevention. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP) – MMWR April 4, 1997, Vol 46, No. RR-8. [Update for cochlear implants] MMWR August 8, 2003 52(31) [Update for Adults for PPSV23] MMWR September 2, 2010, 59(34) [for Children and high risk adolescents to 18] MMWR December 10, 2010, 59; pp 13

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.4:</b> Influenza vaccination	
<b>Description:</b> Percentage of HIV-infected patients <sup>1</sup> who received influenza vaccination within the measurement year <sup>2</sup>	
<b>Numerator:</b>	Number of HIV-infected patients who received influenza vaccination within the measurement year.
<b>Denominator:</b>	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patient refusal of influenza vaccine documented in the chart.</li> <li>2. Hypersensitivity to influenza vaccine or allergy to its components including thimerosal, chicken protein, and egg protein.</li> <li>3. Previous diagnosis of Guillain-Barre Syndrome.</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-infected? (Y/N)</li> <li>2. If yes, is there documentation in the chart that the patient received influenza vaccine in the past 12 months? (Y/N) <ol style="list-style-type: none"> <li>a. Includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of Influenza vaccine in medical record in measurement year</li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• HIVQUAL reports on this measure for grantee under review</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<p>DHSP Benchmark: 90%</p> <p>None available at this time</p>
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Mortality rates from influenza and pneumonia in the clinical population</li> </ul>
<b>Basis for Selection:</b>	
<p>Influenza viruses cause disease among all age groups. While rates of infection are highest among children, rates of serious illness and death are highest among persons aged &gt; 65 years, children less than two years, and persons of any age who have medical conditions that place them at increased risk for complications of influenza, including HIV.<sup>4</sup></p> <p>Influenza vaccination is the primary method for preventing influenza and its severe complications.<sup>4</sup></p> <p>Vaccination has been demonstrated to produce substantial antibody titers against influenza among vaccinated HIV-infected persons who have minimal AIDS-related symptoms and high CD4+ T-lymphocyte cell counts.<sup>3</sup></p>	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**U.S. Public Health Guidelines:**

“As indicated in this report from the Advisory Committee on Immunization Practices (ACIP), annual influenza vaccination is now recommended for....adults and children who have required regular medical follow-up or hospitalization during the preceding year because of ...immunodeficiency (including...human immunodeficiency virus).”<sup>4</sup>

“Because influenza can result in serious illness and because vaccination with inactivated influenza vaccine might result in the production of protective antibody titers, vaccination might benefit HIV-infected persons, including HIV-infected pregnant women. Therefore, influenza vaccination is recommended.”<sup>4</sup>

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Due to the unique nature of this measure and Influenza season/vaccine administration, the measurement period runs from April 1-March 31

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> Centers for Disease Control and Prevention. Prevention and Control of Influenza: Recommendations from the Advisory committee on Immunization Practices (ACIP). MMWR2011; 60(33); pp 1128-1132 2010; 59(rr08); pp 1-62 59(31); pp 989-992.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.5:</b> Hepatitis B screening	
<b>Description:</b> Percentage of patients <sup>1</sup> for whom Hepatitis B screening was performed at least once since the diagnosis of HIV-infection in the measurement year.	
<b>Numerator:</b>	Number of HIV-infected patients who have documentation of Hepatitis B status <sup>2</sup> since HIV diagnosis or initiation of care with provider.
<b>Denominator:</b>	Number of patients who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year
<b>Patient Exclusions:</b>	1. Patient refusal of test.
<b>Data Element:</b>	1. Is the patient HIV-positive? (Y/N) a. If yes, is their documentation of Hepatitis B serologic status in the medical record? (Y/N)
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>○ Electronic Medical Record/Electronic Health Record</li> <li>○ CAREWare, Lab Tracker, or other electronic data base</li> <li>○ Medical record data abstraction by grantee of a sample of records.</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	DHSP Benchmark: 90% None available at this time.
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Incidence of Hepatitis B in clinic population</li> <li>○ Hepatitis B-related morbidity and mortality in the clinic population</li> </ul>
<b>Basis for Selection:</b>	
<p>Hepatitis B virus (HBV) is the leading cause of chronic liver disease worldwide. In developed countries, HBV is transmitted primarily through sexual contact and injection-drug use. Even though risk factors are similar, HBV is transmitted more efficiently than HIV-1. Although up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, only approximately 10% have chronic Hepatitis B, as evidenced by the detection of Hepatitis B surface antigen (HBsAg) in the serum persisting for a minimum of six months.<sup>4</sup></p> <p>HIV-1 infection is associated with an increased risk for the development of chronic Hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic Hepatitis B infection have higher HBV DNA levels and are more likely to have detectable Hepatitis B e antigen (HBeAg), accelerated loss of protective hepatitis B surface antibody (anti-HBs), and increased risk for liver-related mortality and morbidity.<sup>4</sup></p> <p>Co-infection with HIV and HBV can complicate the care and treatment of HIV, and guide the selection of medications for ART.</p>	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**U.S. Public Health Guidelines:**

“It is not clear that treatment of hepatitis B virus (HBV) improves the course of HIV, nor is there evidence that treatment of HIV alters the course of HBV. However several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV co-infection. Therefore, providers should know the HBV status of all patients with HIV. This also will guide the choice of medications for HIV treatment in the context of any possible HBV treatment. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for “all susceptible patients (i.e., antihepatitis B core antigen-negative).”<sup>4,5</sup>

**References/Notes:**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Serologic tests to evaluate for Hepatitis B immunity and chronic Hepatitis B include:

- Hep B Surface Antigen (+/-)
- Hep B Surface Antibody (+/-)
- Additional markers: Hep B Core Antibody (IgG or IgM), Hep B e Antigen

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.  
<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

<sup>5</sup> Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011. Available at  
<http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.6:</b> Substance use assessment																				
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who have been assessed for substance use (alcohol and illicit substances) in the measurement year.																				
<b>Numerator:</b>	Number of patients with HIV infection who were assessed for substance use <sup>2</sup> within the measurement year.																			
<b>Denominator:</b>	Number of patients with HIV-infection who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year																			
<b>Patient Exclusions:</b>	None.																			
<b>Data Element:</b>	1. Is the patient HIV-positive? (Y/N) a. If yes, was the patient assessed for substance use during the reporting period with documentation in medical record? (Y/N)																			
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>○ Electronic Medical Record/Electronic Health Record</li><li>○ CAREWare, Lab Tracker, or other electronic data base.</li><li>○ HIVQUAL reports on this measure for grantee under review</li><li>○ Medical record data abstraction by grantee of a sample of records.</li></ul>																			
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	DHSP Benchmark: 90% IHI Goal: 90% <sup>4,5</sup> National HIVQUAL-US Performance Data: <sup>4</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td></tr><tr><td>Top 10%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Top 25%</td><td>92.3%</td><td>100%</td><td>100%</td></tr><tr><td>Median*</td><td>74.4%</td><td>86.4%</td><td>92.7%</td></tr></table> *from HAB data base					2003	2004	2005	Top 10%	100%	100%	100%	Top 25%	92.3%	100%	100%	Median*	74.4%	86.4%	92.7%
	2003	2004	2005																	
Top 10%	100%	100%	100%																	
Top 25%	92.3%	100%	100%																	
Median*	74.4%	86.4%	92.7%																	
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"><li>○ Substance use-related mortality rates</li><li>○ Rate of substance use-related hospitalizations</li><li>○ Rate of substance use referrals</li></ul>																			
<b>Basis for Selection:</b>																				
Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. It is important to identify co-morbid illness such as substance use, which may complicate ongoing HIV treatment.																				
<b>U.S. Public Health Guidelines:</b>																				
“The chronic and relapsing nature of substance abuse as a biologic and medical disease, compounded by the high rate of mental illness, additionally complicates the relationship between health care workers and IDU. The first step in provision of care and treatment for these individuals is the recognition of the existence of a substance abuse problem. Whereas this is often open and obvious, patients may hide such behaviors from clinicians. Assessment of the patient for the presence of substance abuse should be part of routine medical history taking and should be done in a clinical, straightforward, and nonjudgmental manner” <sup>6</sup>																				

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**References/Notes:**

<sup>1</sup> “Patients” include all patients aged 13 years or older.

<sup>2</sup> Substance abuse assessment: prior history of substance use and abuse, prior substance abuse treatment, current use/abuse of substances. If patient has no history of substance abuse, annual monitoring for changes in substance use patterns is indicated.

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> IHI Measure reads, “Percent of Patients/Patients Assessed for Substance Use and/or Tobacco Use in the Past 12 Months.”

<http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsPatientsAssessedforSubstanceUseandorTobaccoUseinthePast12Months.htm>.

<sup>5</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>.

<sup>6</sup> Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011 <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.7:</b> Mental health assessment																				
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who have had a mental health assessment in the measurement year.																				
<b>Numerator:</b>	Number of HIV-infected patients who received a mental health assessment <sup>2</sup> in the measurement year.																			
<b>Denominator:</b>	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges <sup>3</sup> at least twice in the measurement year.																			
<b>Patient Exclusions:</b>	None.																			
<b>Data Element:</b>	1. Is the patient HIV-positive? (Y/N) a. If yes, did the patient receive a mental health assessment during the reporting period? (Y/N)																			
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>○ Electronic Medical Record/Electronic Health Record</li><li>○ CAREWare, Lab Tracker, or other electronic data base.</li><li>○ HIVQUAL reports on this measure for grantee under review</li><li>○ Medical record data abstraction by grantee of a sample of records.</li></ul>																			
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	DHSP Benchmark: 90% National HIVQUAL-US Data: <sup>4</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td></tr><tr><td>Top 10%</td><td>100%</td><td>100%</td><td>80.6%</td></tr><tr><td>Top 25%</td><td>93.0%</td><td>89.5%</td><td>35.1%</td></tr><tr><td>Median*</td><td>72.9%</td><td>66.7%</td><td>2.2%</td></tr></table> *from HAB data base					2003	2004	2005	Top 10%	100%	100%	80.6%	Top 25%	93.0%	89.5%	35.1%	Median*	72.9%	66.7%	2.2%
	2003	2004	2005																	
Top 10%	100%	100%	80.6%																	
Top 25%	93.0%	89.5%	35.1%																	
Median*	72.9%	66.7%	2.2%																	
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"><li>○ Rate of mental health referrals</li><li>○ Mental health-related hospitalizations</li><li>○ Rate of suicide in the clinic population</li><li>○ Rate of mental health disorders being treated in the clinic population</li></ul>																			
<b>Basis for Selection:</b>																				
Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. Mental health is an important predictor of ART adherence, and therefore may play a substantial role in a patient’s ability to attain viral suppression on HIV medication. <sup>5</sup>																				
<b>U.S. Public Health Guidelines:</b>																				
“Patients living with HIV-infection must often cope with multiple social, psychiatric, and medical issues. Thus, the (initial) evaluation should also include assessment of substance abuse, economic factors, social support, mental illness, co-morbidities, and other factors that are known to impair the ability to adhere to treatment and alter outcomes. Once evaluated, these factors should be managed accordingly.” <sup>6</sup>																				

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

**References/Notes:**

<sup>1</sup> “Patients” include all patients aged 13 years or older.

<sup>2</sup> Mental health screen: documentation of prior mental illness, prior treatment of mental illness, documentation of any current mental health symptoms. If patient has no history of prior mental illness, annual monitoring for symptoms of mental illness (i.e. depression/anxiety) is indicated.

<sup>3</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>4</sup> <http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf>. The Mental Health/Substance Use Subcommittee of the National HIVQUAL Clinical Advisory Committee include the following components for an annual Mental Health Screening for people with HIV: Cognitive function assessment, including mental status; Depression screening; Anxiety screening; Sleeping habits assessment; Appetite assessment; Domestic violence screening; Post Traumatic Stress Disorder screening; Psychiatric history (optional); Psychosocial assessment (optional)

<sup>5</sup> Mellins CA, Havens JF, McDonnell C, et. al *AIDS Care*. 2009 Feb;21(2):168-77.

<sup>6</sup> Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents October 14, 2011 Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.8: Hepatitis B vaccination</b>	
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who completed the vaccination series for Hepatitis B in the measurement year.	
<b>Numerator:</b>	Number of HIV-infected patients with documentation of having ever completed the vaccination series for Hepatitis B <sup>2,3</sup> in the measurement year.
<b>Denominator:</b>	Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges <sup>4</sup> at least twice in the measurement year
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patients newly enrolled in care during the measurement year.</li> <li>2. Patients with evidence of current HBV infection (Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody, or Hep B DNA).</li> <li>3. Patients with evidence of past HBV immunity (Hep B Surface Antibody).</li> <li>4. Patients with documented refusal of Hepatitis B vaccine in medical record.</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-infected? (Y/N) <ol style="list-style-type: none"> <li>a. If yes, does the patient have documentation of Hepatitis B immunity or HBV-infection? (Y/N) <ol style="list-style-type: none"> <li>i. If no, is there documentation that the patient has completed the vaccine series for Hepatitis B?(Y/N)</li> <li>ii. Documentation includes dated records (e.g., personal, school, physician, or immunization registry) as evidence of vaccination, or documentation of administration of vaccine dose(s) in medical record, or combination of outside records and medical records to achieve three doses of vaccine</li> </ol> </li> </ol> </li> </ol>
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• CAREWare, Lab Tracker, or other electronic data base</li> <li>• Medical record data abstraction by grantee of a sample of records</li> </ul>
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	<p>DHSP Benchmark: 90%</p> <p>Published data from the HIV Outpatient Study (HOPS) reports 17% of patients with HIV-infection who were eligible for vaccination received at least three doses of vaccine.<sup>5</sup></p> <p>“Hepatitis B vaccination coverage among adults at high risk...[was] 45% in 2004.”<sup>6</sup></p>
<b>Outcome Measures for Consideration:</b>	<ul style="list-style-type: none"> <li>○ Incidence of Hepatitis B infection in the clinic population</li> </ul>
<b>Basis for Selection:</b>	
HBV is the leading cause of chronic liver disease worldwide. In developed countries, HBV is transmitted primarily through sexual contact and injection-drug use. Even though risk factors are similar, HBV is transmitted more efficiently than HIV-1. Although up to 90% of HIV-1–infected	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

persons have at least one serum marker of previous exposure to HBV, only approximately 10% have chronic Hepatitis B,<sup>3</sup> as evidenced by the detection of HBsAg in the serum persisting for a minimum of six months.

HIV-1 infection is associated with an increased risk for the development of chronic Hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic Hepatitis B infection have higher HBV DNA levels and are more likely to have detectable HBeAg, accelerated loss of anti-HBs, and an increased risk for liver-related mortality and morbidity.<sup>3,7</sup>

There is a protective antibody response in approximately 30% to 55% of healthy adults aged  $\leq 40$  years after the first dose of vaccine. After age 40, the proportion of persons with a protective antibody response after a three-dose vaccination regimen declines. In addition to age, other host factors (e.g., smoking, obesity, genetic factors, and immune suppression) contribute to decreased vaccine response. Response to Hepatitis B vaccination also is reduced in other immune-compromised persons (e.g., HIV-infected persons, hematopoietic stem-cell transplant recipients, and patients undergoing chemotherapy).

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting its use.

#### U.S. Public Health Guidelines:

“Several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV co-infection. Therefore, providers should know the HBV status of all patients with HIV. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for “all susceptible patients (i.e., antihepatitis B core antigen-negative).”<sup>3</sup>

#### References/Notes:

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup> Patients in the middle of the vaccination series on 12/31/x would not be captured in the numerator in year x. They would, if the series was completed on schedule, be captured in year x+1.

<sup>3</sup> Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents —Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. March 24, 2009. Volume 58.  
<http://www.aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=211&ClassID=4>.

<sup>4</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>5</sup> Tedaldi EM, Baker RK, Moorman AC, Wood KC, Fuhrer J, McCabe RE, Holmberg SD; HIV Outpatient Study (HOPS) Investigators. Hepatitis A and B vaccination practices for ambulatory patients infected with HIV. Clinical Infectious Diseases. 2004 May 15;38(10):1478-84.  
(<http://www.journals.uchicago.edu/CID/journal/issues/v38n10/32448/32448.web.pdf>)

<sup>6</sup> Centers for Disease Control and Prevention. Hepatitis B Vaccination Coverage Among Adults —United States, 2004. MMWR 2006;55:509-11  
(<http://www.cdc.gov/mmwr/PDF/wk/mm5518.pdf>)

**FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES**

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<sup>7</sup> Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011. Available at <http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part A

<b>Performance Measure 2.9:</b> Tobacco cessation counseling																																										
<b>Description:</b> Percentage of patients <sup>1</sup> with HIV infection who received tobacco cessation counseling within the measurement year.																																										
<b>Numerator:</b>	Number of HIV-infected patients who received tobacco cessation counseling within the measurement year.																																									
<b>Denominator:</b>	Number of HIV-infected patients who: <ul style="list-style-type: none"><li>• Used tobacco products within the measurement year, and</li><li>• had a medical visit with a provider with prescribing privileges<sup>2</sup> twice within the measurement year</li></ul>																																									
<b>Patient Exclusions:</b>	1. Patients who deny tobacco use throughout the measurement year.																																									
<b>Data Element:</b>	1. Is the patient HIV-positive? (Y/N) <ul style="list-style-type: none"><li>a. If yes, did the patient use tobacco during the reporting period? (Y/N)<ul style="list-style-type: none"><li>i. If yes, did the patient receive tobacco cessation counseling documented in the medical record during the reporting period? (Y/N)</li></ul></li></ul>																																									
<b>Data Sources:</b>	<ul style="list-style-type: none"><li>• Electronic Medical Record/Electronic Health Record</li><li>• CAREWare, Lab Tracker, or other electronic data base</li><li>• HIVQUAL reports on this measure for grantee under review</li><li>• Medical record data abstraction by grantee of a sample of records</li></ul>																																									
<b>National Goals, Targets, or Benchmarks for Comparison:</b>	DHSP Benchmark: 90% National HIVQUAL-US Data: <sup>3</sup> <table><tr><td></td><td>2003</td><td>2004</td><td>2005</td><td>2006</td><td>2007</td><td>2009</td></tr><tr><td>Top 10%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Top 25%</td><td>93.3%</td><td>97.8%</td><td>98.4%</td><td>100%</td><td></td><td></td></tr><tr><td>Median*</td><td>75.8%</td><td>90.0%</td><td>88.2%</td><td>91.7%</td><td>93.0%</td><td>94.1%</td></tr><tr><td>Bottom 10%</td><td></td><td></td><td></td><td></td><td>45.5%</td><td>50.0%</td></tr></table> *from HAB data base								2003	2004	2005	2006	2007	2009	Top 10%	100%	100%	100%	100%	100%	100%	Top 25%	93.3%	97.8%	98.4%	100%			Median*	75.8%	90.0%	88.2%	91.7%	93.0%	94.1%	Bottom 10%					45.5%	50.0%
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Top 25%	93.3%	97.8%	98.4%	100%																																						
Median*	75.8%	90.0%	88.2%	91.7%	93.0%	94.1%																																				
Bottom 10%					45.5%	50.0%																																				
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"><li>○ Rate of head and neck, and lung cancer</li><li>○ Rate of tobacco use in the clinical population</li></ul>																																									
<b>Basis for Selection:</b>																																										
After Kaposi sarcoma and non-Hodgkin lymphoma, lung cancer is the most common cancer among HIV-infected individuals, with an incidence rate that is two to three times higher among HIV-infected individuals than in the general population. <sup>4</sup> . Risk factors associated with an increased risk for bacterial pneumonia, include low CD4+ count, injection-drug use, and cigarette smoking (454). As tobacco use among HIV-infected patients poses significant health risks, tobacco-dependent patients should be provided assistance to enroll in smoking cessation programs. Various studies																																										

FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

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have shown that brief interventions by the clinician to encourage tobacco cessation and offer substitution programs can decrease smoking rates<sup>5</sup> and tobacco use.<sup>6</sup> Cessation reduces the risk of incidence or the progression of tobacco-related diseases and increases life expectancy.<sup>7,8,9</sup> HIV care providers should provide cessation assistance in the form of counseling, pharmacotherapy, or referral to cessation programs.

Tobacco use in all forms is the biggest risk factor for oral cancer. Alcohol abuse combined with tobacco use increases risk. Clinicians should be alert to the possibility of oral cancer when treating patients who use tobacco or alcohol. Patients should be encouraged to not use tobacco and to limit alcohol use in order to decrease their risk for oral cancer as well as heart disease, stroke, lung cancer, and cirrhosis.<sup>10</sup>

The U.S. Preventive Services Task Force (USPSTF)<sup>11</sup> recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco Products, (*Grade: A Recommendation*) and that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke. (*Grade: A Recommendation*).

This USPSTF recommendation applies to adults 18 years or older and all pregnant women regardless of age. The USPSTF plans to issue a separate recommendation statement about counseling to prevent tobacco use in non-pregnant adolescents and children. Various primary care clinicians may deliver effective interventions. There is a dose-response relationship between quit rates and the intensity of counseling (that is, more or longer sessions improve quit rates). Quit rates seem to plateau after 90 minutes of total counseling contact time. Helpful components of counseling include problem-solving guidance for smokers (to help them develop a plan to quit and overcome common barriers to quitting) and the provision of social support as part of treatment. Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone “quit lines.” Combination therapy with counseling and medications is more effective at increasing cessation rates than either component alone. Pharmacotherapy approved by the U.S. Food and Drug Administration and identified as effective for treating tobacco dependence in nonpregnant adults includes several forms of nicotine replacement therapy (gum, lozenge, transdermal patch, inhaler, and nasal spray), sustained-release bupropion, and varenicline.

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**References/Notes**

<sup>1</sup>“Patients” include all patients aged 13 years or older.

<sup>2</sup>A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.

<sup>3</sup>HIVQUAL-US <http://hivqualus.org/>

<sup>4</sup>Meredith S. Shiels, PhD1, Stephen R. Cole, PhD2, Shruti H. Mehta, PhD1, and Gregory D. Kirk, PhD MD. Lung cancer incidence and mortality among HIV-infected and HIV-uninfected injection drug users. *J Acquir Immune Defic Syndr*. 2010 December 1; 55(4): 510–515. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2974802/pdf/nihms-237366.pdf>

<sup>5</sup>Page AR, Walters DJ, Schlegel RP, Best JA. Smoking cessation in family practice: The effects of advice and nicotine chewing gum prescription. *Addict Behav* 1986;11(4):443-6.

<sup>6</sup>Demers RY, Neale AV, Adams R, Trembath C, Herman SC. The impact of physicians' brief smoking cessation counseling: A MIRNET study. *J Fam Pract* 1990;31(6):625-9.

<http://thorax.bmj.com/content/55/12/987.full.pdf+html>  
<http://jama.ama-assn.org/content/278/21/1759.full.pdf+html>

<sup>7</sup>Rigotti NA. Treatment of tobacco use and dependence. *N Engl J Med* 2002;346:506-512.

<sup>8</sup>Lancaster T, Stead L, Silagy C, Sowden A. Effectiveness of interventions to help people stop smoking: findings from the Cochrane Library. *BMJ* 2000;321:355-8.

<sup>9</sup>Methods, Successes, and Failures of Smoking Cessation Programs E B Fisher Jr., E Lichtenstein, D Haire- Joshu, G D Morgan, H R Rehberg *Annual Review of Medicine*, February 1993, Vol. 44, Pages 481-513.

<sup>10</sup>Opportunistic Infections in HIV-Infected Adults and Adolescents, Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *MMWR* 2009;58(No. RR-4)

[http://aidsinfo.nih.gov/contentfiles/Adult\\_OI\\_041009](http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009)

<sup>11</sup>Guide to Clinical Preventive Services, 2010-2011, Recommendations of the U.S. Preventive Services Task Force, p 43- 44 <http://www.ahrq.gov/clinic/pocketgd1011/pocketgd1011.pdf>  
 Available at: <http://www.ahrq.gov/clinic/pocketgd.htm>

Detailed reviews and recommendations about clinical interventions for tobacco cessation are available in the U.S. Public Health Service Clinical Practice Guideline “Treating Tobacco Use and Dependence: 2008 Update” (available at <http://www.surgeongeneral.gov/tobacco>). Tobacco-related recommendations from the Centers for Disease Control and Prevention’s Guide to Community Preventive Services are available at: <http://www.thecommunityguide.org/tobacco/index.html>. This USPSTF recommendation was first published in: *Ann Intern Med*. 2009; 150:551-555.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part B

<b>Performance Measure 2.10:</b> Medical visits	
<b>Description:</b> Percentage of HIV-infected patients who are enrolled in outpatient medical services who had a medical visit with a provider <sup>1</sup> with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting <sup>2</sup> two or more times at least 3 months apart in the measurement year.	
<b>Numerator:</b>	Number of HIV-infected patients who had a medical visit with an HIV provider with prescribing privileges, i.e., MD, PA, NP, two or more times at least 3 months apart in the measurement year.
<b>Denominator:</b>	Number of HIV infected patients who were enrolled in outpatient medical services in the measurement year.
<b>Patient Exclusions</b>	<ol style="list-style-type: none"> <li>1. Patients newly enrolled in care during last six months of the measurement year.</li> <li>2. Patients who were incarcerated during the measurement year.</li> </ol>
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>2. Is the patient HIV-infected? (Y/N)               <ol style="list-style-type: none"> <li>b. If yes, is the patient enrolled in outpatient medical care? (Y/N)</li> <li>2. If yes, did the patient have a medical visit with an HIV provider two or more times, at least 3 months apart within the measurement year?</li> </ol> </li> </ol>
<b>Data Sources:</b>	Casewatch
<b>National Goals, Targets, or Benchmarks for Comparison</b>	DHSP Benchmark: 90%  No national benchmarks identified at this time.
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Rate of patient retention in care</li> <li>○ Rate of HIV related hospitalizations in the measurement year</li> <li>○ Rate of HIV related emergency room visits in the measurement year</li> <li>○ Rate of opportunistic infections in the measurement year</li> <li>○ Mortality rates</li> </ul>
<b>Basis for Selection:</b>  Numerous studies describe the adverse impacts of poor retention in care on patient outcomes. In particular, poor retention in care is associated with the following outcomes: decreased likelihood of receiving antiretroviral therapy; higher rates of antiretroviral therapy failure; increased HIV transmission risk behavior; increased hospitalization rates; and worse survival. Patients with greater initial retention in care had the greatest survival over 5 years of follow-up, and patients with the worst initial retention had the poorest survival <sup>3</sup> Treatment guidelines	

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

recommend to test CD4 at entry into care then follow-up every 3-6 months before ART, every 3-6 months when on ART, then, in clinically stable patients with suppressed viral load, CD4 count can be monitored every 6–12 months.<sup>4</sup> For adherent patients with suppressed viral load and stable clinical and immunologic status for >2–3 years, some experts may extend the interval for HIV RNA monitoring to every 6 months.

All patients who are clinically stable should be monitored at least every 4 months; this includes both patients who are receiving ART and those who are not. Visits may require more frequent scheduling at entry to care, for management of acute problems, or when starting or changing ART regimens.<sup>5</sup>

Patients infected with HIV face a complex array of medical, psychological, and social challenges. A strong provider-patient relationship, the assistance of a multidisciplinary care team, and frequent office visits are key aspects of care. Through both the specific services they provide and their overall approach to patients, clinics can have a substantial impact on the quality of care for HIV-infected persons.<sup>6</sup>

Greater experience among primary care physicians in the care of persons with AIDS improves survival.<sup>7</sup>

**References/Notes:**

<sup>1</sup> A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ARV (antiretroviral) therapy.

<sup>2</sup> An HIV care setting is one which received Ryan White Program funding to provide HIV care and has a quality management program to monitor the quality of care addressing gaps in quality of HIV care.

<sup>3</sup> Giordano, TP. Perspective: Retention in HIV Care: What the Clinician Needs to Know. *Top Antivir Med* 2011; 19(1):12-16, IAS-USA

<sup>4</sup> Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011; 1–167. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed [1/23/2012] [p. 6, Table 3. Laboratory Monitoring Schedule for Patients Prior to and After Initiation of Antiretroviral Therapy (Updated January 10, 2011)].

<sup>5</sup> New York State Department of Health. Primary care approach to the HIV-infected patient. New York: New York State Department of Health AIDS Institute: [www.hivguidelines.org](http://www.hivguidelines.org); April 2011 update. p. 1. <http://www.hivguidelines.org/Content.aspx?pageID=257>

<sup>6</sup> AETC National Resource Center. Guide for HIV/AIDS Clinical Care. U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. January, 2011. Available at: <http://www.aidsctc.org/aidsctc?page=cg-00-00> Accessed February, 1, 2012.

<sup>7</sup> Kitahata MM, Van Rompaey SE, Dillingham PW, Koepsell TD, Deyo RA, Dodge W, Wagner EH. Primary care delivery is associated with greater physician experience and improved survival among persons with AIDS. *J Gen Intern Med*. 2003 Feb;18(2):157-8.

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

### Clinical Performance Measures for Adult /Adolescent Patients: Supplemental Measures – Part B

<b>Performance Measure 2.11:</b> Viral load suppression < 200 copies/mL when on ART									
<b>Description:</b> Percentage of HIV-infected patients on ARV therapy 12 weeks or more before last viral load and with at least one viral load test, with the last viral load undetectable or <200 copies/mL in the measurement year.									
<b>Numerator:</b>	Number of HIV-infected patients on ARV therapy 12 weeks or more before last viral load and with at least one viral load test, with the last viral load undetectable or < 200 copies/mL in the measurement year.								
<b>Denominator:</b>	Number of HIV-infected patients on ARV therapy 12 weeks or more before last viral load test during the measurement year.								
<b>Patient Exclusions:</b>	<ol style="list-style-type: none"> <li>1. Patients who are not on ARV therapy.</li> <li>2. Patients who do not have a viral load test after 12 weeks or more of ARV therapy.</li> <li>3. Patients who were incarcerated during the measurement year.</li> </ol>								
<b>Data Element:</b>	<ol style="list-style-type: none"> <li>1. Is the patient HIV-infected? (Y/N)               <ol style="list-style-type: none"> <li>a. If yes, was the patient on ARV therapy at least 12 weeks or more? (Y/N)                   <ol style="list-style-type: none"> <li>i. If yes, did the patient have at least one viral load test? (Y/N)                       <ol style="list-style-type: none"> <li>1. If yes, was the last viral load test undetectable ('&lt;') or &lt;200 copies/mL (list the date and result).</li> </ol> </li> </ol> </li> </ol> </li> </ol>								
<b>Data Sources:</b>	<ul style="list-style-type: none"> <li>• Electronic Medical Record/Electronic Health Record</li> <li>• Medical/laboratory record data abstraction of a sample of records</li> <li>• Health Way LA Data System</li> </ul>								
<b>National Goals, Targets, or Benchmarks for Comparison</b>	<p>DHSP Benchmark: 80%</p> <p>National HIVQUAL-US Data: <sup>4</sup></p> <p>Last viral load undetectable or &lt;200, among patients on ARV therapy &gt;12 weeks</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td></td><td>2009</td></tr> <tr> <td>Top 10%</td><td>94.1%</td></tr> <tr> <td>Median</td><td>78.6%</td></tr> <tr> <td>Bottom 10%</td><td>50%</td></tr> </table>		2009	Top 10%	94.1%	Median	78.6%	Bottom 10%	50%
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Median	78.6%								
Bottom 10%	50%								
<b>Outcome Measures for Consideration</b>	<ul style="list-style-type: none"> <li>○ Rate of opportunistic infections in the measurement year</li> <li>○ Rate of patients with progression to AIDS in the measurement year</li> <li>○ Mortality rates</li> <li>○ Virologic suppression rates (In+Care Campaign <a href="http://www.incarecampaign.org/">http://www.incarecampaign.org/</a>)</li> </ul>								

## FEE-FOR-SERVICE AND ADDITIONAL REIMBURSEMENT INCENTIVES GUIDELINES

<b>Basis for Selection:</b>	
<p>The plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment as viral load is the most important indicator of response to ART<sup>5</sup>.</p> <p>Measure reflects important aspects of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.</p>	
<b>Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents:</b>	
<p>Plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment, because viral load is the most important indicator of response to antiretroviral therapy (ART) (AI). Analysis of 18 trials that included more than 5,000 participants with viral load monitoring showed a significant association between a decrease in plasma viremia and improved clinical outcome [1]. Thus, viral load testing serves as a surrogate marker for treatment response [2] and can be useful in predicting clinical progression [3-4]. The minimal change in viral load considered to be statistically significant (2 standard deviations) is a threefold, or a 0.5 log<sub>10</sub> copies/mL change.</p> <p>Optimal viral suppression is generally defined as a viral load persistently below the level of detection (&lt;20–75 copies/mL, depending on the assay used). However, isolated “blips” (viral loads transiently detectable at low levels, typically &lt;400 copies/mL) are not uncommon in successfully treated patients and are not thought to represent viral replication or to predict virologic failure [5]. In addition, low-level positive viral load results (typically &lt;200 copies/mL) appear to be more common with some viral load assays than others, and there is no definitive evidence that patients with viral loads quantified as &lt;200 copies/mL using these assays are at increased risk for virologic failure [6-8]. For the purposes of clinical trials the AIDS Clinical Trials Group (ACTG) currently defines virologic failure as a confirmed viral load &gt;200 copies/mL, which eliminates most cases of apparent viremia caused by blips or assay variability [9]. This definition may also be useful in clinical practice. (See <b>Virologic and Immunologic Failure</b>.)</p> <p><b>At Initiation or Change in Therapy.</b> Plasma viral load should be measured before initiation of therapy and preferably within two to four weeks, and not more than eight weeks, after treatment initiation or after treatment modification. Repeat viral load measurement should be performed at four to eight week intervals until the level falls below the assay’s limit of detection.</p> <p><b>In Patients Who Have Viral Suppression but Therapy Was Modified Due to Drug Toxicity or Regimen Simplification.</b> Viral load measurement should be performed within two to eight weeks after changing therapy. The purpose of viral load monitoring at this point is to confirm potency of the new regimen.</p> <p><b>In Patients on a Stable Antiretroviral Regimen.</b> Viral load should be repeated every three to four months or as clinically indicated. In adherent patients who have suppressed viral loads for more than two to three years and who are at stable clinical and immunological status, some clinicians may extend the interval to every six months.</p> <p><b>Monitoring in Patients with Suboptimal Response.</b> In addition to viral load monitoring, a number of additional factors should be assessed, such as no adherence, altered pharmacology, or drug interactions. Patients who fail to achieve viral suppression should undergo resistance testing</p>	

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to aid in the selection of an alternative regimen. <sup>5</sup>
<b>References/Notes:</b>
Guidelines state that viral load should be measured at least every three to four months depending on the stage of the disease. The timeframe of six months was determined by clinical expert consensus for the purpose of this measure, but can and should be measured at more frequent intervals if needed.
<p><sup>1</sup>“Patients” include all patients aged 13 years or older.</p> <p><sup>2</sup>A “provider with prescribing privileges” is a health care professional who is certified in their jurisdiction to prescribe ART, i.e. MD, PA, NP.</p> <p><sup>3</sup>IHI Measure reads, “Percent of Patients/Patients with a Viral Load Test in the Past 4 Months.” <a href="http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/Percentofpatientswithvirallloadtestinthepast4months.htm">http://www.ihl.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/Percentofpatientswithvirallloadtestinthepast4months.htm</a>.</p> <p><sup>4</sup> HIVQUAL-US Performance Data Report for Ryan White Part C and Part D Funded Programs (January 1, 2009 to December 31, 2009) <a href="http://hivqualus.org/index.cfm/22/10039">http://hivqualus.org/index.cfm/22/10039</a></p> <p><sup>5</sup> Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. October 14, 2011; 1–167. Available at <a href="http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf">http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf</a>. Accessed [1/23/2012].</p>